NATIONAL QUALITY FORUM

+ + + + +

HEALTH AND WELL BEING
STEERING COMMITTEE MEETING

+ + + + +

TUESDAY
April 29, 2014

+ + + + +

The Steering Committee met at the
National Quality Forum, 9th Floor Conference
Room, 1030 15th Street, N.W., Washington,
D.C., at 8:30 a.m., Thomas McInerney and Sarah
Sampsel, Co-Chairs, presiding.

PRESENT:

THOMAS MCINERNEY, MD, Co-Chair
SARAH SAMPSEL, MD, Co-Chair
CHISARA ASOMUGHA, Centers for Medicare &
      Medicaid Services
JOHN AUERBACH, Northeastern University
MICHAEL BAER, AmeriHealth Caritas Family of
      Companies
RON BIALEK, Public Health Foundation
JUAN EMILIO CARILLO, Weill Cornell Medical
      College, NYP
JANE CHIANG, American Diabetes Association
ERIC FRANCE, Kaiser Permanente
RENEE FRAZIER, Healthy Memphis Common Table
RON INGE, Delta Dental of WA
DAVID KROL, Robert Wood Johnson Foundation
MARGARET LUCK, Mary's Center for Maternal &
      Child Care
PATRICIA MCKANE, Michigan Department of
      Community Health
AMY MINNICH, Geisinger Health System
JACQUELINE MOLINE, North Shore Long Island
      Jewish Health System

MARCEL SALIVE, National Institute on Aging
KATIE SELLERS, Association of State and
        Territorial Health Officials
JASON SPANGLER, Amgen, Inc.
MIKE STOTO, Georgetown University
ROBERT VALDEZ, Robert Wood Johnson
        Foundation Center for Health Policy
ARJUN VENKATESH, Yale University School of
        Medicine

NQF STAFF:

HELEN BURSTIN, Senior Vice President,
        Performance Measurement
ANN HAMMERSMITH, JD, General Counsel
ADEELA KHAN, Project Manager, Performance
        Measurement
ALLEN LEAVENS, MD, Senior Director
ELISA MUNTHALI, Managing Director
KAITLYNN ROBINSON-ECTOR

ALSO PRESENT:

KRISHNA ARAVAMUDHAN, Dental Quality Alliance
JAMES CRALL, Dental Quality Alliance
JILL HERNDON, Dental Quality Alliance
ROBYN NISHIMI, Healthcare Quality Consultant
PAMELA OWENS, AHRQ
PATRICK ROMANO, UC Davis, AHRQ*

* present by teleconference

T-A-B-L-E O-F C-O-N-T-E-N-T-S

T-A-B-L-E O-F C-O-N-T-E-N-T-S (con't)

PAGE

1   P-R-O-C-E-E-D-I-N-G-S

2   (8:33 a.m.)

3   MS. MUNTHALI: Hello everyone and

4   good morning. My name is Elisa Munthali. I'm

5   the Managing Director for the Performance

6   Measurement Department at NQF. Welcome to the

7   Standing Committee Meeting for Health and Well

8   Being.

9   Before I turn the meeting over to

10   Ann Hammersmith, who is our general counsel

11   who will lead us, lead the Committee through

12   introductions and the disclosure of interest

13   process, there are a couple of housekeeping

14   items that I wanted to bring to everyone's

15   attention.

16   We just wanted to remind everyone

17   that this meeting is open to the public. It

18   is being recorded and transcribed so we ask

19   that if you'd like to make a comment please

20   remember to turn on your microphones and speak

21   into the mike.

22   There are restrooms just beyond

 1 the elevators for all of those who are here in

 2 the conference center and they're to the

 3 right. There will be several opportunities

 4 for breaks throughout the next two days,

 5 including lunch.

 6   And there will be opportunities

 7 for members of the public to make comment on

 8 the Committee's deliberations as well. And if

 9 you are trying to access Wi-Fi the user name

10 is "guest," all lowercase, and the password is

11 "NQF," uppercase, "guest."

12   And we ask for your full

13 attention. We ask that you put your phones on

14 mute throughout the deliberations of the

15 meeting and if you'd like to make a phone call

16 or answer a call you may do so by stepping

17 out.

18   I'd also like to also introduce my

19 colleagues who are working on the project,

20 Adeela Kahn, who is the Project Manager,

21 Kaitlynn Robinson-Ector, who's over there,

22 who's a Project Analyst, Ashley Morsell, who's

1   another Project Manager who is providing

2   analytics for this project, and Robyn Nishimi

3   who is our Project Consultant.

4   And with that I'll turn it over to

5   Ann Hammersmith.

6   MS. HAMMERSMITH: Thank you,

7   Elisa. As Elisa said we're going to combine

8   introductions and disclosures. If you recall

9   probably several months ago you received a

10 rather long form from us in which we asked you

11 about your professional activities.

12   So what we'd like to do this

13 morning is not have you recite your resume,

14 not have you recite every single thing you

15 might have put on the form, but we are looking

16 for you to disclose things that are relevant

17 to the work of this Committee, relevant to the

18 work of this Committee only.

19   We are especially interested in

20 your disclosure of grant activity, research,

21 or consulting. I do want to stress that NQF's

22 conflict of interest regime is a bit different

1 from others, we don't look solely at financial

2 conflicts of interest.

3   You may have something that you

4 did as a volunteer, you may have sat on a

5 committee with Professional Society or

6 something like that where you were not paid,

7 if that is relevant to the work today we would

8 expect you to disclose that.

9   And, last but not least, I want to

10 remind you that you are sitting as an

11 individual on this Committee, you are here

12 because you're an expert, you're not

13 representing your employer, and you are not

14 representing anyone who may have nominated you

15 to serve on the Committee.

16   So with that let's go around the

17 table, tell us who you're with and if you have

18 anything you would like to disclose.

19   MR. MCINERNEY: Hi. Tom

20 McInerney, primary care pediatrician from

21 Rochester, New York and immediate past

22 president of American Academy of Pediatrics

1 and I have nothing to disclose.

2 MS. SAMPSEL: Good morning, I'm

3 Sarah Sampsel. I'm a Senior Research

4 Associate with Impact International and I will

5 just disclose I am working on a research

6 project for CMS for end stage renal disease,

7 so if some of these measures are under

8 consideration for that project.

9 And then I worked at NCQA for

10 approximately six years, however that COI has

11 expired and I did not work on any of the

12 measures that are coming through here today.

13 MS. KHAN: Sorry to interrupt. I

14 just want to add that we're actually going to

15 be passing out little slips of paper that have

16 a two or 3-year term listed on them and so

17 we're just going to have you pick from the cup

18 and if you could just announce the number that

19 you get so we know to mark whether you're here

20 for a two or a 3-year term. So, did you get,

21 Sarah?

22 MS. SAMPSEL: Yes.

1   MS. KHAN: Okay, great.

2   MR. MCINERNEY: I drew a 2-year

3   term.

4   MS. SAMPSEL: Mine is two as well.

5   MR. BAER: Next? My name is Mike

6   Baer. I am a family doctor from AmeriHealth

7   Caritas Pennsylvania, a managed care

8   organization in Pennsylvania. I have no

9   disclosures, and two years.

10   MR. KROL: Hi, everybody, I'm

11   David Krol. I'm a pediatrician from

12   Princeton, New Jersey. I work for the Robert

13   Wood Johnson Foundation and I have nothing to

14   disclose.

15   MS. MINNICH: Good morning. My

16   name is Amy Minnich. I am from Geisinger

17   Health System, currently work in Health

18   Services as Director for Case Management and

19   I have nothing to disclose.

20   MR. KROL: And I'm a 2-year term.

21   MS. MINNICH: I'm the first lucky

22   number three.

1   MS. FRASIER: Oh, okay. Maybe you

2   took the three, good. That's what they say in

3   cards. In the casino you got my card. Good,

4   thank you.

5   I'm Renee Frasier, CEO of Healthy

6   Memphis Common Table. I think the only thing

7   we should disclose is that we do public

8   reporting and we are a grantee of Robert Wood

9   Johnson's aligning forces for quality

10   initiative and as part of that we do look at

11   these measures and we use NQF as our

12   guideline.

13   But I did want to disclose that

14   and I think that would appropriate for me to

15   disclose. And also serving on another NQF

16   Committee, Population Health, so that would be

17   appropriate I believe.

18   Oh, I got your card, too. Three

19   years, now what does that mean? I'll have to

20   find out.

21   (Laughter)

22   MS. LUCK: I'm Margaret Luck. I'm

1   Director of Quality and Outcomes at Mary's

2   Center, a federally qualified health center

3   with sites here in the District of Columbia

4   and in Maryland, and I have no disclosures.

5   I'll go down to the bottom. Two.

6   MR. SALIVE: Hi, I'm Marcel

7   Salive. I'm a Medical Officer at the National

8   Institute on Aging, part of NIH here in

9   Bethesda, no disclosures.

10   MR. FRANCE: Good morning, my name

11   is Eric France. I'm a pediatrician and public

12   health physician for Kaiser Permanente

13   Colorado and I am two years and have nothing

14   to disclose.

15   MR. SALIVE: And I picked the 3-

16   year number.

17   MALE PARTICIPANT: Sorry about

18   that.

19   (Laughter)

20   MS. ASOMUGHA: Good morning, my

21   name is Chisara Asomugha. I'm a pediatrician,

22   I'm also the Senior Technical Advisor for the

1 Centers for Clinical Standards and Quality at

2 CMS. Two years.

3   MR. SPANGLER: Good morning. I'm

4 Jason Spangler, I'm a preventative medicine

5 physician. I currently am the Executive

6 Director of Medical Policy at Amgen, the

7 biotech company, where I'm in charge of our

8 quality strategy and quality activities.

9   So my disclosure would be related

10 to any products that Amgen has, but there are

11 none that are relevant to this Committee or

12 the measures that we're looking at, and if

13 there happen to be some I'll disclose that at

14 that time.

15   The only other thing I'd mention

16 is I am also on another NQF panel. I'm on the

17 Cardiovascular Steering Committee as well.

18   MS. CHIANG: Good morning. My

19 name is Jane Chiang and I am the Senior Vice

20 President at the American Diabetes

21 Association. I'm a pediatric endocrinologist.

22 My disclosures, so I oversee medicine there

1   including the Clinical Practice Guidelines.

2   I am a liaison to the Clinical

3   Recognition Program at NCQA and I am also the

4   liaison to various collaborative

5   organizations.

6   MR. SPANGLER: Also, excuse me,

7   sorry. I was three years.

8   MS. CHIANG: I'm also three.

9   MR. AUERBACH: Good morning. I'm

10   John Auerback and I'm currently a professor at

11   Northeastern University and also oversee an

12   institute there called the Institute on Urban

13   Health Research and Practice, and I'm formerly

14   the State Health Commissioner for

15   Massachusetts and before that, the City of

16   Boston's Health Commissioner.

17   I have previously worked in those

18   capacities looking at population-based

19   measures that look more broadly at community

20   settings, non-clinical settings, and

21   population-based measures and I'm still

22   involved in doing some of that work, but I

1   don't have a specific disclosure to make at

2   this time. A 3-year term.

3   MS. SELLERS: Good morning. My

4   name is Katie Sellers. I am the Chief Science

5   and Strategy Officer at the Association of

6   State and Territorial Health Officials.

7   I do not have anything to disclose

8   and I will be serving a 2-year term.

9   MS. MCKANE: Hi, I'm Patricia

10   McKane and I'm a Senior MCH epidemiologist at

11   the Michigan Department of Community Health

12   and I, as part of that work with MDCH and also

13   with the Association of Maternal Child Health

14   I do look at population indicators and I've

15   worked on life course indicators but nothing

16   specific that's what these indicators are

17   going to look at and I also got a 2-year term.

18   MR. INGE: Good morning. My name

19   is Ron Inge and I am a general dentist and I

20   noticed that I'm representing the forgotten

21   part of the body and also my name is also

22   missing off the list of the standing

1 committee.

2   I am a Chief Dental Officer for

3 Delta Dental of Washington and Executive

4 Director of the Institute for Oral Health. I

5 have no disclosures and 3-year term.

6   MS. MOLINE: Good morning, I'm

7 Jacki Moline. I'm the Chair of Population

8 Health. I'm an internist and occupational

9 medicine specialist.

10   I receive grant funding to run

11 large clinical programs that have nothing to

12 do with the measures that we're discussing

13 today and I have a 3-year term.

14   MR. BIALEK: Good morning. I'm

15 Ron Bialek, President of the Public Health

16 Foundation and nothing specific to disclose

17 other than also working on population health

18 measures outside of the clinic settings.

19   And my thing says 3-hour term, so

20 I don't what that --

21   (Laughter)

22   MR. BIALEK: No, it's a -- Okay,

1   okay. Yes, right, right. No, a 3-year term,

2   thank you.

3   MR. VENKATESH: My name is Argun

4   Venkatesh and I'm an emergency physician at

5   Yale University and I engaged in measure

6   development activities for the Yale Center for

7   Outcomes Research as well as the American

8   College of Emergency Physicians, none of which

9   are measures being considered here.

10   I do have to recuse myself from

11 measures 0272 and 0274 as I was part of the

12 technical expert panels that informed their

13 development. Team three.

14   MR. VALDEZ: Good morning, I'm

15 Robert Valdez. I'm a Health Services

16 Researcher. I'm currently a professor at the

17 University of New Mexico.

18   And as far as disclosures, I am on

19 the National Advisory Board of the Prevention

20 Institute and they're engaged in a variety of

21 projects doing population health measures,

22 developments, none of which are part of our

1   discussions today, and I'm on group two.

2   MR. CARILLO: Good morning, Emilio

3   Carillo. I am Vice President for Community

4   and Population Health at New York Presbyterian

5   Hospital and associate professor in medicine

6   and public health at Weill Cornell Medical

7   School.

8   I have no other work on measures,

9   relating or otherwise. I do participate and

10   take lead in two CMS and New York State

11   healthcare delivery release sign projects,

12   which do use some of the measures that we look

13   at.

14   I also serve on the care

15   coordination NQF expert panel and I drew a 3-

16   year term and I have nothing to disclose

17   otherwise.

18   MS. HAMMERSMITH: Okay, thank you

19   for those disclosures. One thought that I

20   want to leave you with is that you're a very

21   important part of an effective conflict of

22   interest regime.

1   If you think that you have a

2   conflict at any time please do speak up. If

3   you think that a fellow committee member has

4   a conflict or if you think that someone is

5   behaving in a biased manner, please don't sit

6   in silence, we want you to tell us.

7   You are always welcome to bring it

8   up humbly in a meeting, you can go to your

9   Chair who will then consult with NQF staff, or

10   you can go directly to NQF staff.

11   So in that spirit, based on the

12   disclosures this morning, do you have anything

13   that you want to discuss with each other or

14   any questions? Okay, thank you.

15   MS. MUNTHALI: Thank you, Ann.

16   There is one more staff introduction that we'd

17   like to make. Helen?

18   MS. BURSTIN: Good morning,

19   everybody, sorry to be a couple minutes late.

20   Helen Burstin, I'm the Senior VP here

21   overseeing our work in performance

22   measurement.

1   Lots of familiar faces, I don't

2   know why some of you were sad to get three

3   years, that's a wonderful thing. The logic of

4   the standing committees is, and for some of

5   you who've been in our committees know, it's

6   such a steep learning curve that in some ways

7   you get comfortable evaluating the measures

8   and more than anything else you get

9   comfortable with each other.

10   You have a good sense of who knows

11   which area, you're very comfortable relying on

12   each other's expertise. So even if you got

13   two years the wonderful news is we would love

14   to have you reapply for a second term and the

15   idea of doing two and 3-year years is just

16   that the committee doesn't turn over at once

17   since we're just starting this.

18   And we're really excited to

19   actually have this group, focus on this topic,

20   it is, you know, one of the pillars of the

21   National Quality Strategy, the National

22   Prevention Strategy, and there's just so much

1   more work I think we need to do in this area.

2   You're going to have a lot of very

3   interesting sort of methodologic questions,

4   you're going to hopefully help us explore this

5   whole issue of levels of analysis, you know,

6   this question of are there certain measures

7   that are better at a population level but

8   maybe not work as well at a clinician level?

9   Are there certain measures that

10   logically cascade to let us really be able to

11   see, you know, the different effects of

12   clinician versus population versus community,

13   so all of those issues are front and center.

14   This is such an important area and

15   we recognize a lot of these issues are going

16   to probably, a lot of these measures will

17   generate a lot of discussion and that's okay.

18   You're first measure will take an

19   hour to review and that's okay because it

20   happens all the time and I think we've finally

21   built it into our timelines so you won't fall

22   too far behind.

1   But you have great, experienced

2   Chairs who have both been with us before,

3   Sarah, on our last population health project,

4   and then Dr. McInerney chairing our prior

5   child health project.

6   So I think you're in great hands.

7   Thank you for all your efforts and we'll be

8   here in and out over the next couple of days,

9   and a fabulous staff as well who will take

10   great care of you. Thanks.

11   MS. KHAN: Good morning everyone.

12   I just wanted to go over some ground rules and

13   the rules of our Standing Committee. So

14   you've all been selected to serve either a two

15   or 3-year term.

16   You'll be working with NQF staff

17   to achieve the goals of this project, which is

18   to review all of our measures and evaluate

19   them against the NQF criteria.

20   We'll be going over the criteria

21   briefly before we start evaluating, but

22   essentially you'll be making recommendations

1   to the NQF membership for endorsement, you'll

2   be responding to comments submitted during the

3   review period, and also respond to any

4   directions from the CSAC, which is our

5   Consensus Standards Approval Committee.

6   You'll also be in charge of

7   overseeing the Health and Well Being Portfolio

8   of Measures, which we'll also be going over in

9   a little bit more detail later on in the

10 presentation.

11   Just to go over some meeting

12 expectations, NQF is continuing to improve our

13 committee meetings based on input from a

14 variety of stakeholders and we've made a few

15 changes to our meeting process since the last

16 time maybe some of you have been here.

17   We'd like to recognize that we're

18 fortunate to have the measure developers

19 present and we'll be asking them to briefly

20 introduce their measure as they come up for

21 discussion.

22   The selected workgroup

1 representatives will then begin the discussion

2 of the measures in relation to the measure

3 evaluation criteria. We've also provided a

4 designated place for the developers, they'll

5 be right up here in the front.

6 At the main table during

7 introduction and discussion of their measures

8 by sitting at the table they'll be more easily

9 able to respond to questions from the

10 committee and correct any issues about their

11 measures during their discussion.

12 As in the case with the committee

13 members, developers are asked to please put up

14 your card when you would like to respond to a

15 question or correct any statements about the

16 measure.

17 During the measure evaluation

18 committee members can often offer suggestions

19 for improvement of the measures, but these

20 suggestions can only be considered for future

21 improvements.

22 The committee is expected to

1   evaluation and make recommendations on the

2   measures per the submitted specifications and

3   testing.

4   This multi-stakeholder group

5   brings varied perspectives, values, and

6   priorities to the discussion and respect for

7   differences of opinion and collegial

8   interactions among the committee members and

9   measure developers is expected.

10   The workgroup and the full

11 committee meeting agendas are typically quite

12 full and all of the committee members, co-

13 chairs, developers, staff, are responsible for

14 ensuring that the work of the meeting is

15 completed during the time allotted.

16   Just some additional ground rules,

17 the committee members should be prepared,

18 having reviewed the measures beforehand.

19 Again, base the evaluation and recommendations

20 on the measure evaluation criteria and

21 guidance, remain engaged in the discussion

22 without distractions, attend the meeting at

1   all times except during the breaks, keep

2   comments concise and focused, avoid dominating

3   a discussion and allow other to contribute,

4   and indicate agreement without repeating

5   what's already been said.

6   So these are the eight steps of

7   our consensus development process, the first

8   is the call for nominations followed by our

9   call for candidate standards, which is when

10   our developers provide their measures to us.

11   Currently we're in the standards

12   review, the committee review of the submitted

13   and maintenance measures recommended for

14   endorsement.

15   After this meeting we'll be

16   drafting our report and then the report will

17   be going to public and member comment. We'll

18   have a call to reconcile all the comments that

19   we receive and then the measures will go to

20   our membership for voting.

21   After they've gone through voting

22   they'll be sent to our Consensus Standards

1   Approval Committee followed by our Board of

2   Directors and then if there are any appeals

3   they'll be received after the measures are

4   approved by the Board.

5   This is just a high level overview

6   of our NQF measure criteria. The first is

7   important to measure and report, that's a must

8   pass criteria. The measure won't be able to

9   move forward unless it passes this criteria.

10   The second is scientific

11   acceptability of the measure properties. This

12   is also a must pass criteria and this is where

13   we're looking at the testing, so the

14   reliability of validity testing of the

15   measures.

16   Then we'll be assessing

17   feasibility and use and usability. And,

18   finally, we'll be voting on the overall

19   endorsement of the measure and we'll be

20   looking at harmonization and selection of best

21   in class once the measures have been endorsed

22   by the committee.

1   And so I'll turn it over Elisa now

2   to, she's going to be doing a quick portfolio

3   review of the measures in our portfolio.

4   MS. MUNTHALI: Thank you, Adeela.

5   As Adella and Helen both mentioned the

6   committee, the members of the committee will

7   be serving multiple terms, we hope consecutive

8   terms.

9   And we are hoping that that will

10   give you more insight in the measurement

11   frameworks that make up the measures in the

12   Health and Well Being Portfolio at NQF, but

13   that you'll be also more aware of the

14   portfolio and the measures and how important

15   they are within the context of the NQF

16   portfolio.

17   We also hope that it will enable

18   you to better address those issues around

19   standardization and achieving parsimony within

20   the NQF portfolio and you'll be able to better

21   address and identify the measurement gap areas

22   in Health and Well Being.

1   We are hoping that you will also

2   become more familiar with the Health and Well

3   Being and population health work that is

4   taking place at NQF.

5   Our colleague Allen Leavens will

6   be talking about two very important projects

7   after I'm done speaking around population

8   health and for that reason we're trying to

9   make sure that the work that's happening

10   across all of the projects is informative and

11   not duplicative.

12   We're also hoping that you'll be

13   able to better receive input from external

14   stakeholders and be able to provide feedback

15   on how the portfolio should evolve.

16   MS. BURSTIN: Could I just add one

17   quick one? And one more task I'd like to put

18   on your plate which is often times there are

19   great measures that are in use out there in

20   the real world that don't come our way.

21   So we've sort of affectionately

22   referred to this as the need to prospect for

1   measures. So I think part of what we'd also

2   love to have you do for us over the years is

3   as you come upon a measure that may be in use

4   in a community, in a clinic in a given

5   locality, please let us know and we'd be

6   delighted to work with them, partner with them

7   with a measure developer.

8   We've been working on this concept

9   of an incubator. You're able to take those

10   ideas from the field, get them in, get them

11   standardized and tested. So please consider

12   that one of your roles as well.

13   MS. MUNTHALI: And as Helen also

14   mentioned earlier the work that we're doing at

15   NQF, particularly around Health and Well Being

16   is it has really been informed by the National

17   Quality Strategies three part aim of better

18   care, making sure that populations are

19   healthy, and making sure that that care that

20   they receive is affordable.

21   Specifically we're focusing beyond

22   the clinical care delivery system, but looking

1   at, you know, the provision of the clinical

2   preventative services across the life span,

3   across settings, but also looking at healthy

4   lifestyle behaviors and those social and

5   economic and environmental determinants of

6   health.

7   The work that we're doing here at

8   NQF around Health and Well Being was also

9   informed by our first project, our first

10 population measures project, and in that

11 because it was the first around we did

12 significant foundational work which included

13 a background paper that was developed by Don

14 Jacobson at the Public Health Institute and

15 Steve Teutsch at the L.A. County Department of

16 Public Health.

17   A big piece of their paper was an

18 environmental scan of existing population and

19 community level measures, but there was also

20 guidance on how we should be measuring and

21 assessing population health, the determinants

22 of health, and improvement activities.

1   Steve and Don also wanted to

2   emphasize the importance of making sure that

3   the clinical care delivery system and public

4   health system were aligned in health

5   improvement.

6   And also that NQF really adopt an

7   integrated measurement, framework to include

8   total population, the determinants of health,

9   and improvement activities. And so that work

10   led to a 2-phase project.

11   In the first phase many around the

12   table, Ron and Sarah, were a part of that

13   work. We reviewed and endorsed 19 clinical

14   preventative services in immunization

15   measures.

16   And as you remember from the

17   preceding slide that is a tenet of the NQS and

18   the committee had some, you know, very strong

19   recommendations for developers.

20   There were a number of

21   immunization measures that you'll see tomorrow

22   when we talk about gaps and we talk about

1   harmonization that came forward.

2   And they expressed a desire for

3   developers to work together on a universal

4   measure that integrates multiple populations.

5   There were also concerns that some of the

6   measures that came forward were not

7   standardized with current standards from the

8   Advisory Committee on immunization practices.

9   And then the second phase we were

10   focused on the other two parts of the NQS, the

11   part that focuses on healthy lifestyle

12   behaviors and the social determinate, so those

13   broader population health measures.

14   Despite targeted outreach we only

15   received nine measures, five of which were

16   endorsed. The committee had a number of

17   recommendations and one was to really bring

18   into NQF those measures that address the

19   social, the upstream determinates of health

20   around social, economic, and environment

21   factors, measures that assess the physical

22   environment including air pollution, built

1   environments, and clean water.

2   They also wanted to see

3   population-based blood pressure measures so

4   that those can be aligned with the Million

5   Hearts Campaign and they wanted more

6   comprehensive population health measures,

7   those that looked beyond process but were

8   composites that took into account outcomes and

9   access and structure and population

10   experience.

11   So in the NQF portfolio, in the

12   entire portfolio of -- Is it about 700

13   measures?

14   FEMALE PARTICIPANT: Six twenty-

15   four.

16   MS. MUNTHALI: Six twenty-four.

17   There are about 70 endorsed measures in Health

18   and Well Being. They cut across settings and

19   life span and they include the following

20   domains and sub-topics, health related

21   behaviors and practices to promote healthy

22   living, community level indicators of health

1   and disease and community interventions.

2   We have a number of measures that

3   assess primary prevention and/or screening and

4   some measures that address modifiable social

5   economic and environmental determinates of

6   health.

7   And what I've done here is just to

8   give you a sample of some of those measures,

9   I've included those major domains as column

10   headings and the number across the Health and

11   Well Being Portfolio are in parentheses.

12   As you can see we have quite a few

13   measures as I mentioned before in primary

14   prevention and screening, about 25, and we

15   have 12 in the community level indicators of

16   health and disease category.

17   Not as many social determinate

18   measures and even fewer health related

19   behavior measures. At the bottom, I think

20   it's the third column, the last two rows,

21   you'll see two measures.

22   One of them is an osteoporosis

1 screening measure that has been assigned to

2 the Endocrine Project and another HIV and AIDS

3 screening measure that's assigned to our

4 Infectious Disease Project.

5 I bring these here to you just to

6 emphasize the importance of us looking beyond

7 just those measures that have been assigned to

8 his particular committee.

9 It's important for us as staff to

10 make sure that we are aligning our work across

11 and that you're informed about all of the

12 other work that is related to Health and Well

13 Being, health related behaviors, primary

14 prevention, those modifiable social, economic,

15 environmental determinates of health, and the

16 community level indicators of Health and Well

17 Being that are outside of this project.

18 And so with regards to our current

19 measures under review there are 15 measures

20 across levels of analysis including healthcare

21 and providers and communities and the

22 committee will be reviewing these measures,

1   some have been previously endorsed.

2   Six are newly submitted oral

3   health measures and we've included a listing

4   of the measures here. These are the eight

5   measures from AHRQ, they address the community

6   level indicators of health and disease and the

7   six oral health measures that I mentioned

8   before, and one primary prevention screening

9   measure on breast cancer screening.

10   And so I don't know if you have

11   any questions on the portfolio or on the

12   evaluation process or on the project, the

13   scope and the goals?

14   MR. AUERBACH: This is John

15   Auerbach. I'd start out by saying I apologize

16   if this is something you already said or I

17   should've known already from reading the

18   material.

19   But in terms of the initial

20   measures that we're looking at today and

21   tomorrow those don't seem to include the ones

22   that were the modifiable, environmental, and

1 social determinant measures.

2   Is that because they're not

3 assigned to this committee or because we'll be

4 addressing those but at a later time?

5   MS. MUNTHALI: That is a good

6 question. You actually will be addressing

7 those at a later time. They're not due for a

8 maintenance review and so once a measure is

9 endorsed there's a 3-year period in which it's

10 under maintenance.

11   Developers can submit annual

12 updates to those measures. They're not

13 material changes, perhaps updates to coding.

14 After three years they go through the same

15 process, reviewing it against the importance

16 to measure and report, scientific

17 acceptability of the measure properties,

18 feasibility, use and usability.

19   So those will probably, we do have

20 some that were due for a review in this

21 project but we had to push them out to the

22 next round of Health and Well Being projects,

1 so you'll see more of those, about ten of

2 those, and we're hoping to put out a call for

3 additional measures, too, and hopefully more

4 of those will come in.

5   MR. FRANCE: This is Eric France.

6 Could you remind the expected meeting

7 schedules over the subsequent years? We've

8 had a certain experience to date and I'm

9 curious what it's going to look like in the

10 next year and the next year.

11   MS. MUNTHALI: In terms of the in-

12 person meetings?

13   MR. FRANCE: Both phone calls and

14 in-person meetings.

15   MS. MUNTHALI: Okay. So I'll have

16 Adeela talk about the schedule. She will talk

17 about it at the end of the meeting, but I'll

18 have her go over it now.

19   But in terms of the next in-person

20 meeting that will be contingent on when we

21 receive funding for the next project and so we

22 are hoping, we are very hopeful that we'll

1   receive funding for the next project sometime

2   early next year.

3   And so that in-person meeting will

4   probably happen by mid-year 2015 I would say.

5   And so I'll turn it over to Adeela to talk

6   about this particular project.

7   MS. KHAN: Sure. So as I

8   mentioned before we had our measure submission

9   deadline in February. We had our workgroup

10   calls in March and April and our in-person

11   meeting is today, April 29th and 30th.

12   After this, our report is going to

13   be posted for public and member comment June

14   4th to July 3rd and we'll have a call with the

15   committee August 6th to discuss the comments

16   that we received.

17   After that it'll go to a member

18   vote in August as well and then to CSAC in

19   September and the Board in September as well.

20   So at that point in time the CSAC and the

21   Board, the Steering Committee, they're not

22   really doing anything, they're not doing a

1   heavier lift, it's usually the co-chairs

2   that'll be attending the CSAC meeting and the

3   Board meeting to talk about any issues that

4   come up during the in-person meeting.

5   And then if we receive an appeal

6   we would convene the committee again to

7   discuss the contents of the appeal and we

8   would process that. I don't know if you have

9   anything to add?

10   MS. MUNTHALI: No, not to add to

11   that, but I did want to get back to that point

12   of the modifiable determinants of health.

13   That has been a constant struggle for us. It

14   was for our first population health project

15   and for those who were on the project you can

16   definitely chime in.

17   That's an area that we're hoping

18   to address. Not just through this project,

19   but also through the project that Allen

20   Leavens will talk about. This is a community

21   action guide, so really trying to put out a

22   practical guide that communities can use to

1   improve population health.

2   But what it also does is to put

3   forward a core set of measures and resources

4   that communities can use and I think this goes

5   back to the point that Helen brought up.

6   If you hear of any measures that

7   have been used at the community level, knowing

8   that this is, you know, NQF hasn't been in

9   this space for long and many people may not

10   know about our endorsement process. We'd love

11   to hear about it.

12   There were several recommendations

13   that our past committee had in our final

14   report and I'll circulate that and how we can

15   get more people to the table and through our

16   endorsement process.

17   MR. BIALEK: There was one

18   particular struggle I recall with the

19   population health measures before which came

20   down to some of the policy measures like the

21   tobacco tax where it's a valid, reliable, huge

22   impact on populations, et cetera.

1   And I'm wondering if NQF has

2 grappled with that any longer if policy types

3 of measures are now up for consideration or if

4 they're still pretty much off the table?

5   MS. BURSTIN: That's a great

6 question, Ron, I mean I don't think anything's

7 truly off the table, it all goes back to the

8 criteria. If it's evidence-based, if it's

9 reliable and valid I think it's fair game.

10   I think one of the challenges last

11 time in particular was this very interesting

12 issue and many of you have lived in this sort

13 of population health space specifically of

14 what's the locus of accountability, I think is

15 where it got a bit complex.

16   You're going to see that today,

17 for example, with the AHRQ measures,

18 community-based measures, you know. So for

19 example, State-based measures that baby

20 percent tax.

21   I think we should, in some ways it

22 would great to actually have a measure like

1 that come forward and actually begin to chew

2 on what is the actually evidence? What kind

3 of testing is required, a population level

4 versus a clinician level?

5   So I don't think we have any

6 guardrails, Ron, I think this is really an

7 opportunity for, particularly as you hear more

8 about the work Allen will describe of really

9 trying to think about what is the right place

10 for standardized measures in that broader

11 population health space.

12   Anything you want to add, Robyn,

13 or Elise, or anything?

14   MR. VALDEZ: I guess I have one

15 question I think that follows from what Helen

16 just said which was something we struggled

17 with in the workgroup but I think applies to

18 the measure evaluation criteria.

19   Going forward is that historically

20 we've thought about the purpose of the NQF

21 endorsement to be for measures that are

22 suitable for public reporting and

1   accountability and I think that can envision

2   what public reporting looks like for a lot of

3   these measures.

4   Accountability becomes a lot more

5   challenging in the absence of accountability

6   programs that may fit what is a varying

7   definition of community between measures.

8   And so if a measure is specified

9   at the County or at the State or maybe not

10 even clearly within what community, how do we,

11 what's the guidance on envisioning

12 accountability because I could see it being

13 used for a variety of things in the future but

14 it may not be how we discuss it over the next

15 couple days?

16   MS. BURSTIN: Another good

17 question and one certainly, as Ron knows and

18 others, we struggled with the last round as

19 well and I think at this point it's so unclear

20 exactly what accountability will be in our

21 sort of emerging healthcare system.

22   I think it's fine to just have

1   measures come in and then I think we also

2   heard on the last committee was that, you

3   know, our co-chair kept making the point as a

4   State Health Officer, I was accountable for

5   those measures.

6   So I think it's just not our

7   traditional lens of the doc, the nurse, the

8   clinic accountability, it is a larger level of

9   accountability and these are the kind of

10 things we'd love to explore with you as we

11 kind of get this work off and going.

12   MS. FRASIER: I would just make

13 the comment, it's the whole reason I agreed to

14 serve, is to figure out how we do this, how we

15 figure out the accountability beyond the

16 individual provider side because it's a much

17 broader landscape of what impacts well being

18 and I think it's the only reason I agreed to

19 serve.

20   MS. BURSTIN: And we're glad you

21 did, Renee, because I think one of the other

22 challenge as well is if you have a measure

1 that's at the community level do you also want

2 to have sort of a companion measure that

3 allows the clinicians in that community to see

4 how they're doing and how comparable do those

5 need to be is another really important issue.

6   Is it enough to say to say they're

7 sort of in the same general area? You're

8 looking at smoking and smoking, but A may not

9 be specified the same way, or do you want to

10 have them comparable enough so that you're not

11 looking at measurement noise and you're

12 actually looking at true signal.

13   So there's are all the kinds of

14 issues we'll exploring.

15   MS. MUNTHALI: Okay. So we'll

16 turn it over to Allen Leavens who's our Senior

17 Director in Strategic Partnerships. Allen

18 will first talk about the MAP Families of

19 Population Health Measures and the Community

20 Action Guide, which we both work on.

21   MR. LEAVENS: Great. Thank you,

22 Elisa, and good morning to everyone. So this

1   first slide is showing the three population

2   health projects that NQF has currently

3   ongoing.

4   And the Health and Well Being

5   endorsement project, you can see on top, which

6   you're all here today to work on, and then the

7   MAP Family of Population Health Measures is a

8   project looking at basically the application

9   of these types of measures.

10   And the Population Health

11   Community Action Guide, which Elisa just

12   eluded to, is a much broader project looking

13   not only at the measures, but how can

14   communities take steps toward improving

15   population health with their populations.

16   So each of these projects is

17   aligned around the National Quality Strategy

18   three part aim, particularly the Health and

19   Well Being component, but what we've been

20   trying to do with all of these projects is

21   loop in the stakeholders and the committees

22   from each of the projects so that we're not

1 working in isolation.

2   Each of these projects has

3 information and input from the committees that

4 can valuable to the other committees. So

5 today I'm just going to take a little bit of

6 time to go through where we are with the other

7 two projects and then we'll be interested in

8 your input on those.

9   So just to give everybody a little

10 context in case you're not familiar with MAP,

11 the Measure Applications Partnership

12 originated through the Affordable Care Act and

13 basically the purpose is to convene multi-

14 stakeholder groups to provide input on

15 selection of quality measures for public

16 reporting payment and other programs.

17   So someone had brought up this is

18 sort of the traditional, what folks at NQF

19 think about in terms of the measures that are

20 endorsed, these are the types of programs that

21 we've traditionally thought about that MAP

22 weighs in on.

1   So in terms of definitions for

2   family of measures as well as core measure

3   sets, families of measures are intended to be

4   basically a group of measures that span

5   programs, settings, level of analysis, and

6   populations for specific topic areas related

7   to the National Quality Strategy.

8   So we have a family of measures

9   focused on safety, care coordination, diabetes

10   and cardiovascular, which would be a

11   prevention treatment of the leading causes of

12   mortality and we've recently just convened the

13   group to focus on the population health family

14   of measures.

15   Core measure sets are derived from

16   the families so if you think about having a

17   family for each of these components of the

18   National Quality Strategy then you could draw

19   from each of those families, say if you're

20   trying to focus on a specific care setting

21   like outpatient or hospital, what are the

22   right measures from each of the National

1   Quality Strategy priority areas that are felt

2   to be high value that apply for each of those

3   settings, so basically just subsets of the

4   families of measures.

5   So what was interesting for the

6   MAP task force that weighed in on the

7   population health family of measures is that

8   we were starting to think a bit more broadly

9   about the application of measures beyond the

10   traditional programs that MAP weighs in on.

11   So one of the task force members

12   suggested developing use cases to help

13   everybody kind of think how that might

14   actually apply.

15   So the first use case, again, more

16   traditional looking at hospital and clinician

17   programs such as hospital value based

18   purchasing, physician quality reporting

19   system, et cetera.

20   The next level up was accountable

21   care organizations. It's not a big jump from

22   the first use case, but trying to think a

1   little bit more systemwide and how measures

2   might be used more at a population level

3   rather than just an individual clinician or

4   hospital setting.

5   And then the next level was

6   community health needs assessment. Now this

7   still has somewhat of a healthcare focus

8   because it's driven by nonprofit hospitals,

9   but thinking more broadly not just in the

10   clinical setting but looking into the

11   community and what are the needs of that

12   community in terms of trying to improve more

13   upstream determinants of health.

14   And just, actually we had those

15   three use cases and then when the committee

16   met it was felt that we didn't have something

17   that even pushed the boundaries far enough so

18   someone suggested a public health use case

19   which wasn't explicitly defined but could be

20   something like a health department or a social

21   services agency but thinking even more broadly

22   beyond a typical clinical setting.

1   So some of the topic areas that

2   the group used in terms of developing what we

3   called high leveraged opportunities were very

4   similar to what Elisa described for the

5   categories that you're using to think of the

6   measures as they're coming through for

7   endorsement such as the prevention and

8   treatment, typical measures, immunizations, et

9   cetera, maternal child health, nutrition,

10   physical activity and then some of the more

11   upstream measures like social determinants of

12   education, poverty, et cetera.

13   So those were the broad categories

14   that the group used in terms of trying to

15   think about what measures existed and what

16   measures were still needed.

17   And so what you see up here are

18   areas that the group specifically identified

19   as GAP areas for measures. So the measures

20   that were selected for the family are still

21   tentative. I didn't put those up because

22   we're still finalizing those.

1   But even among the measures that

2   were selected these were areas that were felt

3   to still be lacking in both endorsed measures

4   and even in some cases indicators or other

5   metrics that may exist.

6   MR. CARILLO: Take questions now

7   or later?

8   MR. LEAVENS: We can start for

9   questions now. Just put it under a mike,

10   please.

11   MR. CARILLO: Any measures in

12   terms of culture, cultural competency,

13   language, health literacy, in that realm in

14   this domain?

15   MR. LEAVENS: Yes. I mean I don't

16   if it's captured specifically there but that

17   did come up in the group discussion. We also

18   have patient and family-centered care family

19   and I think it came up more directly in that

20   family of measures.

21   MR. CARILLO: Right, because

22   that's an important consideration, population

1   health.

2   MR. LEAVENS: Right. So, again,

3   this --

4   MR. MCINERNEY: Another question,

5   sorry.

6   MR. LEAVENS: Sure.

7   MR. MCINERNEY: I just saw that

8   the Institutes of Medicine has started to

9   address the social determinants of health and

10   they have an initial set of recommendations

11   and I wonder if there'll be some harmonization

12   between what we're doing and what they're

13   doing?

14   MR. LEAVENS: A great point. So

15   we did think about some, particularly for the

16   other project that I'll talk about in a

17   second.

18   Some of these other resources that

19   we have to look to, particularly IOM, some of

20   the work that is going around, healthy people,

21   and these other efforts that are focusing on

22   population health and we definitely want to

1   leverage that work forward.

2   So I won't go into each of these

3   in detail, but you can see that they do align

4   with a lot of the things that Elisa was

5   talking about and thinking more broadly about

6   upstream determinants of health rather than

7   just the typical clinical focus even if those

8   are prevention-oriented, which I think even a

9   step beyond those.

10   So the other project that we'll

11   talk about a little bit, and Elisa is also

12   very involved in this and Renee is also on

13   that committee, so please, you know, jump in

14   if I miss anything.

15   But essentially what this project

16   is focusing on is taking a much further step

17   back and looking not just at measurement but

18   how do you establish best principles for

19   bringing together the right stakeholders to

20   improve the health of a community?

21   So you can see some of the

22   questions that guided this work bringing the

1   right individuals and stakeholder groups

2   together.

3   The processes and methods that are

4   evidence-based and can most effectively bring

5   about improvements in health, what data

6   exists, the right measures, what incentives

7   drive alignment and coordination, and then

8   also thinking about affordability of all these

9   interventions that are needed to effectively

10   improve health.

11   So this project has been going on

12   since last Fall. There are multiple

13   stakeholders involved. The first year of the

14   project has involved doing an environmental

15   scan of existing efforts, so, again, the IOM

16   work, there's a lot of work being done through

17   the Government through CDC, AHRQ, HRSA, and

18   others that we've looked at.

19   A lot of collaborations, there's a

20   strong effort to do called the Practical

21   Playbook, that's doing something that's

22   somewhat similar, so we did essentially an

1   environmental scan to make sure that we're

2   trying to capture the good work that others

3   are already doing and incorporate it into this

4   work rather than duplicating existing work.

5   And what you see here is a list of

6   ten, what we call key elements, that looking

7   across all these different efforts were found

8   to be emphasized as important to work on

9   improvements in population health.

10   And I'll just go through these

11   real quickly, but the first step is really

12   looking, doing a self-assessment to see where

13   your organization is in terms of their

14   efforts.

15   So looking at your strengths and

16   weaknesses and what you really accomplish,

17   making sure you have the right leadership

18   within your organization and across

19   organizations that are collaborating together,

20   establishing an organizational planning and

21   priority setting process to make sure that you

22   have clear focus on your goals, doing a

1 community health needs assessment and asset

2 mapping process, so this is something that

3 really received a lot of emphasis because

4 essentially until you know what the needs are

5 for a particular community and what strengths

6 you already have it's difficult to make a

7 forward progress.

8   An agreed upon prioritized set of

9 health improvement activities, so once you

10 know what needs exist and your strengths how

11 do you go about making those improvements and

12 making sure you're using evidence-based

13 practices as part of that effort.

14   And then Number 6 is particularly

15 relevant to this group and also the MAP task

16 force and that's the selection and use of the

17 measures and performance targets that are

18 needed to achieve your goals.

19   Number 7, audience-specific

20 strategic communication, so this is something

21 that was just brought up in terms of making

22 sure, you know, everybody understands, using

1   plan language, what you're trying to

2   accomplish.

3   Number 8, joint reporting on

4   progress, so this ties in closely to the

5   measures making sure that it's very

6   transparent, what results are being achieved

7   or aren't being achieved, and that those are

8   areas that still need improvement.

9   And then the last two, looking

10   more broadly in terms of if your effort is

11   successful how you scale that out to either

12   other communities or even more broadly within

13   your current community and how do you sustain

14   this effort over time particularly given that

15   many projects start based on a grant that will

16   only exist for a few years and then you need

17   some sort of plan in place to make sure that

18   you can sustain that effort over time.

19   So the current state of this

20   project is we've just created a draft, the

21   committee has created a draft, we're calling

22   Action Guide, that was recently put up for

1   public comments and we've received a lot of

2   positive feedback.

3   That will be discussed actually

4   this Thursday, so if you're really motivated

5   I would encourage you to listen in to that web

6   meeting on Thursday for a couple hours to take

7   a look at the guide, it's still up on our

8   site, and we would be happy to receive

9   additional feedback on that. Thank you.

10   MR. BIALEK: I recognize that the

11   Community Action Guide goes well beyond

12   governmental public health, but the question

13   is, you know, I look at this and I think about

14   National Voluntary Accreditation for public

15   health agencies and also a lot of the quality

16   improvement and performance management efforts

17   going on in public health today and I'm

18   wondering how this aligns with those

19   activities?

20   MR. LEAVENS: So we actually have,

21   Kaye Bender is our co-chair for the committee,

22   so --

1   MR. BIALEK: Oh, I know.

2   MR. LEAVENS: Yes, yes. So she's

3   definitely, yes, she's been a great asset to

4   the group and we're definitely trying to stay

5   aligned with that effort.

6   MS. SAMPSEL: John?

7   MR. AUERBACH: Could you go back

8   to the previous working group, the group that

9   was the application of population health

10 measures?

11   And maybe I, could you summarize

12 what the outcome will be of that? Is there a

13 product or a deadline for the release of some

14 set of recommendations?

15   MR. LEAVENS: Right. So the

16 measure applications partnership actually has,

17 we're working on three different what we're

18 calling families of measures.

19   One for population health and then

20 the two others, we'll each be choosing a sort

21 of set of measures related to that particular

22 National Quality Strategy area.

1   So the one for population health

2   will have a defined set of both NQF endorsed

3   measures as well some non-endorsed measures

4   that relate to these topic areas and that will

5   be included in a report that will put up for

6   public comment in June and then the final

7   report will be released July 1st.

8   And the intent of those measures

9   traditionally has been to help support MAP

10   workgroups and the selection of measures for

11   the federal programs, such as PQRS, Hospital

12   Value-Based Purchasing, et cetera.

13   But, again, with the use cases the

14   task force was starting to try to think more

15   broadly how can, for instance, align better

16   with private efforts not just the federal

17   programs, but if, say individuals are, and

18   trying to establish and improvement program in

19   their community, what sort of measures might

20   they want to look to first as high value that

21   have been sort of vetted by this committee and

22   with stakeholder input to say that these are

1   good measures that you may want to start with

2   or at least look at.

3   MR. AUERBACH: May I ask just

4   maybe a follow-up question? It's just related

5   to the issue that, you know, I think is

6   admirable of trying to have alignment between

7   these various processes.

8   Because I noted as we had our

9   telephone conversations about the measures

10   that we're looking at today that there were a

11   number of measures, for instance we were, my

12   subcommittee was looking at diabetes where

13   there were natural complimentary, what might

14   be called broader population measures that

15   were suggested or just came up through that

16   process.

17   But we really try to stay focused

18   on the clinical measure in front of us. On

19   the other hand it just seemed like that was an

20   opportunity for us to think creatively about

21   whether there was something connected to that

22   specific clinical measure that might be worth

1   considering at a population level in terms of

2   thinking about social determinants of health

3   or modifiable indicators.

4   So is there a thought about what

5   to do when that occurs? Is it inappropriate

6   for us in those discussions to say, you know,

7   to broaden those discussions to say okay,

8   we've talked about the clinical measure, let's

9   talk for a few minutes about whether or not

10   there might be some population-based measure

11   that might correlate well with that for, that

12   might be suggested to these other activities

13   that are underway?

14   MR. LEAVENS: Yes.

15   MS. MUNTHALI: No, I think that's

16   definitely within the parameters and call of

17   the committee and I would suggest that we

18   probably do that tomorrow during our

19   discussion of measurement GAP areas and

20   harmonization because we don't want to kind of

21   cloud the valuation of the measures that are

22   in front of us, but we also want to take away

1   from the richness of this to help inform not

2   just this project but all of the other work

3   that we have around population health.

4   MR. CARILLO: Yes, just following

5   up on Ron's point, you know, as some of you

6   probably know the IRS, as part of Schedule H,

7   basically has a requirement that every

8   institution, private or otherwise, to maintain

9   their tax exempt status must conduct a

10   community health needs assessment.

11   So this is something that's so

12   wide sweeping across the Country, but I think

13   that there should be some alignment with that

14   along with the other things that Ron

15   mentioned.

16   MR. LEAVENS: So I'll just make a

17   quick comment on that. Actually that third

18   use case where we talked about the community

19   health needs assessment is directly driven by

20   that in sort of thinking about how perhaps the

21   MAP family of measures may help support groups

22   that are trying to think about what measures

1   do they need to accomplish that.

2   MR. VALDEZ: Robert Valdez. In

3   many ways the ten best practices, or whatever

4   it is you called them that's coming out in

5   your report, in many ways reflect the

6   learnings that come out of the American

7   Hospital Association's Foster McGaw prize

8   winners set of elements that made them winners

9   and why they were actually, to move population

10   health orientations out of the hospital and

11   into the community.

12   So I think this lines up fairly

13   well with those activities and if they could

14   be at least illustrated that way you can bring

15   this list to life actually.

16   MS. MUNTHALI: I just wanted to

17   add one more thing. I did circulate to the

18   committee the draft Action Guide. I'll do so

19   again and encourage you to participate on the

20   call on May 1st.

21   You might not want to sit in

22   another meeting, but it's just a short call

1   from 12 noon to 2:00 p.m. Eastern time on May

2   2nd, 1st sorry, on Thursday. I'll send that

3   information to you as well.

4   So during that call we will

5   discuss the comments that were received during

6   the public comment period that Allen mentioned

7   and hopefully further refine the Guide before

8   we put out the guide for year one later on

9   this year.

10   MR. LEAVENS: So, thank you, and

11   if there are any other questions or input I

12   will be happy to receive those. Thank you.

13   MS. KHAN: Thanks, Allen. I guess

14   we can turn it over to our co-chairs now to

15   lead the rest of the meeting.

16   MS. SAMPSEL: Great. So, thank

17   you, Allen, for that overview and we are now

18   going to move into the measure evaluation and

19   review section of our Agenda.

20   And before doing that, you know,

21   just wanted to bring up some general reminders

22   about what we want to do through this process.

1   I think, and hopefully, most everyone had the

2   opportunity to participate in at least one of

3   the workgroup calls over the past few weeks,

4   and those really set the stage for this

5   conversation here today.

6   But they're also reminders

7   regarding the measures and reviewing the

8   measures as they're specified and presented to

9   us.

10   You know, in an ideal situation

11   there are perfect measures and they meet all

12   the criteria that we all want to cover, but

13   the reality is, is, you know, we're basing

14   measures on evidence as well as use and how

15   they were developed by each of the measure

16   developers.

17   So one of the changes in the

18   process that Elisa mentioned earlier is that

19   the measure developers will have an

20   opportunity to introduce their measures to us

21   today as well as be here for any questions

22   that we have.

1   I, personally, from serving on

2 other standing committees think that is a

3 great improvement, especially for those

4 measures that we're not as familiar with.

5   We'll be reviewing a number of

6 dental measures today and, you know, a lot of

7 us aren't familiar with the data that supports

8 dental measures as well as some of that

9 scientific background because it's not the

10 typical diabetes or heart disease type

11 measures.

12   So as we go through this part of

13 the section the developers will introduce

14 their measures at the start and, you know, for

15 those that are here in person they'll have

16 lovely front row seats up here towards the

17 front of the table.

18   And then we'll have the workgroup

19 members who had been assigned the measures to,

20 between each of us go through and bring out

21 the most salient points of each measure for

22 the entire group to discuss, ask questions, to

1 lead us into our formal evaluation.

2   I think there will be a break

3 before we go into our first one, not a break,

4 but more of one for NQF staff to hand us all

5 our little voting mechanisms, make sure they

6 all work, and that's part of the process as

7 well, is ensuring that those votes are

8 captured and we will ask that everybody makes

9 sure they're paying attention, that these

10 little voting mechanisms are working for

11 everybody.

12   With that, Tom, do you have

13 anything else you want to add?

14   MR. MCINERNEY: No, that was

15 great, thanks.

16   MS. SAMPSEL: Elisa?

17   MS. MUNTHALI: That's perfect.

18   MS. SAMPSEL: Okay. Then our

19 first measure this morning is the

20 Gastroenteritis Admission Rate and I think

21 that's Mike Stoto and Jacki Moline.

22   MS. KHAN: I just want to check

1   with Kathy, do we have Pamela Owens and

2   Patrick Romano and Carol Stocks on the phone?

3   OPERATOR: No, ma'am, they haven't

4   joined yet.

5   MS. KHAN: Okay.

6   MS. SAMPSEL: So I think what

7   we're going to do since the AHRQ folks have

8   not joined yet this morning is we're going to

9   skip ahead in the Agenda a bit and go ahead

10   and start with the dental measures, and we do

11   have a representative here from the Dental

12   Quality Alliance who's going to introduce the

13   measure set before we get going in our

14   conversations.

15   Okay, so now we're going to have a

16   five to 10-minute break. So if folks could

17   come back and be ready to start by a quarter

18   of.

19   (Whereupon, the foregoing matter

20   went off the record at 9:35 a.m. and went back

21   on the record at 9:45 a.m.)

22   MS. SAMPSEL: Okay, folks, if we

1 can go ahead and get seated we're going to get

2 started again.

3   So, with that, as introduced prior

4 to our brief little break we are going to jump

5 to the dental measures and we're going to

6 start it off with having the Dental Quality

7 Alliance and Dr. Crall and --

8   FEMALE PARTICIPANT: Krishna

9 Aravamudhan.

10   MS. SAMPSEL: -- well we're just

11 going to go with Krishna, are going to

12 introduce their measure set and then we'll go

13 ahead and start our discussion. So I will

14 turn it over to the two of you.

15   MS. ARAVAMUDHAM: I'd like to

16 start off by really, really thanking the

17 committee for letting us do this and provide

18 you a quick overview of our measures.

19   There are six measures that were

20 submitted and we'd like to take this

21 opportunity to address the concerns that were

22 expressed by the workgroup, the comments that

1   were made up front, and some of these go

2   across all the measures so hopefully we'll be

3   able to give you some additional input from

4   our end on how things work and what our

5   thought processes were as we develop these

6   measures.

7   So thank you very much for

8   indulging us and I will start off, and I'll

9   team with Dr. Crall. I'd like him to

10   introduce himself as well before he speaks.

11   I am the lead staff for the Dental

12   Quality Alliance and simply am the messenger

13   here and hopefully we'll bring you accurately

14   the thought processes that went in.

15   Dr. Crall is the chair of our

16   measure development committee that led all

17   this work. It took us two years to put all of

18   this together and we're so glad to be here at

19   this point.

20   Over the last two years we've put

21   together a whole set of measures that deals

22   with the pediatric population. It's a set of

1 ten measures, but we've chosen to only submit

2 six to NQF due to a number of reasons,

3 including time and resources that it takes to

4 prepare an NQF submission.

5   So we took the most, you know, the

6 six of these and then submitted to NQF. I

7 jump straight to the concerns that were

8 expressed by the workgroup and try to address

9 each of these.

10   The first concern, of course, was

11 the lack of outcome measures and that most of

12 these measures are access or process measures.

13 Dentistry and dental data is very, very

14 limited in terms of lacking any diagnostic

15 coding in the system.

16   We simply don't have diagnostic

17 codes in the claims data for us to be able to

18 measure outcomes. All of these measures are

19 based off of dental claims data. These are

20 meant for programmatic plan level assessment.

21   So given that broad limitation we

22 simply couldn't go down the path of outcome

1   measures. Is my mike okay?

2   MALE PARTICIPANT: Move back --

3   MS. ARAVAMUDHAM: Okay, move back

4   a little. Okay. So we couldn't measure

5   outcomes that's the first thing. The next big

6   concern that was expressed by the workgroup,

7   of course, was the concept of dental versus

8   oral health services.

9   For this portion I'm going to turn

10   to Dr. Crall to take us through the thought

11   process that we had.

12   MR. CRALL: Oops, sorry. Thank

13   you, Krishna. So thank you again for the

14   opportunity, both to hear from the workgroup

15   in advance and to be here today to give you

16   the overview of these measures.

17   As Krishna said the DQA's a fairly

18   new organization, launched just a little over

19   three years ago over in the Humphrey Building

20   here in Washington and then we put together

21   the structure and have been working on these

22   measures ever since.

1   The initial set of measures really

2   reflect to some degree, as Krishna indicated,

3   the limitations of data that are widely

4   available, but we believe because we wanted to

5   have measures that were broadly impactful

6   across both public sector programs as well as

7   private commercial programs, that we wanted to

8   start with a set of measures that actually

9   could be widely used and for which data would

10   be available.

11   So I'm going to talk just briefly

12   about this notion about dental services and

13   oral health services because it is an area

14   that if you're not sort of immersed in this

15   may strike you as a little unusual.

16   So as I mentioned we're looking

17   for measures that will really apply broadly

18   across public programs for children, being

19   primarily Medicaid and the CHIP Program,

20   although clearly with the advent of the ACA

21   and the inclusion of pediatric services,

22   including oral health services, as the States

1 look to implement those with guidance from

2 DHHS.

3   That will be a relevant universe

4 as well as well as just kids who are covered

5 by commercial plans, employer sponsor

6 benefits. So the whole DQA was actually

7 started at the behest of CMS.

8   They came initially to the ADA and

9 asked them to convene a group, a broad group

10 stakeholders, and we have about 30 members of

11 the DQA now including several federal

12 agencies, all the dental provider

13 organizations, but also organizations like the

14 joint commission and the AMA, we have AHIP.

15   So we have a fairly broad group

16 that we've looked to try to get input from and

17 to reach consensus as we put forward these

18 measures.

19   We looked to develop measures that

20 were applicable in the current day

21 marketplace. Always, of course, with an eye

22 on the future and we know there's a great deal

1   of speculation about how benefits will be

2   transformed or changed going forward, but we

3   are looking to develop measures that could be

4   immediately applicable.

5   So we know from data compiled by

6   the National Association of Dental Plans that

7   roughly 99 percent of the dental benefits that

8   are provided in this Country are provided

9   through what are known as standalone dental

10   plans.

11   And at the State level,

12   particularly in public programs, what that

13   means is that many States have chosen to what

14   is so called carve out dental benefits and

15   they deal with those directly, not under some

16   kind of a global arrangement.

17   And typically even when there is a

18   global arrangement it's very common for the

19   overarching entity to subcontract out with a

20   standalone dental plan to provide those

21   benefits.

22   They simply have the

1 infrastructure, they have the networks, and

2 it's a different sector, not that there isn't

3 some overlap between the two and not that many

4 groups aren't working to try to build better

5 integration across the various health

6 disciplines.

7 So that's the rationale for us

8 starting with dental measures and oral health

9 measures. I'll say that we, the DQA as

10 Krishna mentioned, we developed a broader set

11 of measures and we were able to bring forward

12 for the DQA right now.

13 So in our measures we have

14 measures that parallel the CMS 416 approach

15 and this is fairly new within CMS. Up until

16 about 2010 they looked at only dental measures

17 and dental defined all the way back to October

18 '89 as services provided by or under the

19 supervision of a dentist.

20 In 2010 CMS changed its EPSDT

21 reporting requirements that States comply with

22 and added some additional measures that are

1   referred to as oral health measures.

2   And those oral measures, you know,

3   it's a little bit of a cumbersome definition.

4   The term non-dentist has been used over time,

5   a lot of people have, you know, some concern,

6   you know, they just don't get it when you say

7   non something, but that's basically the way

8   that they are defined.

9   And in the CMS parlance it's

10   licensed practitioners that is not a dentist,

11   so it's provided by or under the direction of

12   somebody who's not a dentist.

13   And the examples that they provide

14   include things like pediatricians or family

15   physicians or nurse practitioners or dental

16   hygienists, who in some States are allowed to

17   practice without direct supervision in

18   typically what's known as community based

19   practice.

20   So CMS using the segmentation of

21   dental services, oral health services, and

22   then they also include a measure that is both

1 so that you get the combination.

2 So if you look at the data from a

3 recent CMS 416 report you basically see that

4 over 97 percent of all children receive dental

5 services. Only about 7 percent receive oral

6 health services and the overlap between the

7 two is about 4 percent.

8 So, you know, as I said, there's

9 been a lot of work over a decade or more,

10 probably closer to two decades, because a

11 certain general's report was done and, you

12 know, an oral health was done in the year

13 2000.

14 But still it's slow to change

15 systems as you know. So the DQA we want to

16 clear up the misconception, this is not just

17 about something that a dentist would directly

18 do.

19 As long as it's under some sort of

20 a system or arrangement where the dentist is

21 the responsible person for supervising or

22 authorizing the care, other types of providers

1   including dental therapists, advanced practice

2   therapists, which are relatively new and used

3   in a few States in this County, and dental

4   hygienists could be included.

5   The oral health services as I

6   mentioned earlier are primarily capturing data

7   that are provided by medical primary care

8   providers.

9   So in our overall DQA measure set

10   we have multiple denominators and the

11   denominators do this differentiation between

12   dental services, oral health services, or the

13   combined measure.

14   We also took some direction from

15   measures that had already been endorsed by NQF

16   and so we know in the annual dental visit

17   measure, the HEDIS measure, it's reference to

18   visits with a dental practitioner.

19   On the primary care side you have

20   primary care as prevention as a measure 1419

21   and then you also have children who receive

22   preventative dental and that must have seen a

1   dentist.

2   So that helped to formulate our

3   approach up to this point. And with that I'm

4   going to turn it over to Krishna.

5   MS. ARAVAMUDHAM: Thank you very

6   much. So that was in terms of the dental and

7   oral health services component that the

8   workgroup had significant concerns on

9   throughout all the different measures.

10   There were also some concerns

11   regarding the exclusion language, the intent

12   of what we wanted to do is very similar to

13   what the workgroup expressed. We simply

14   picked up the language from what CMS currently

15   has.

16   So we are totally willing to

17   editorially revise the footnote that exists

18   for the exclusion to make it clearer if it is

19   not so, the intent is definitely what the

20   workgroup suggested.

21   The other two concerns that were

22   expressed were very specific to the sealant

1   measure and the care continuity measure. With

2   the sealant measure there was some concern

3   based on why is this limited to a specific age

4   group, a specific tooth, and so on and so

5   forth.

6   So the reason is we followed the

7   evidence-based guidelines very, very closely.

8   The evidence-based guidelines, and there's

9   very strong evidence from Cochrane Reviews,

10 we've tried to make sure that we present it to

11 you within our evidence forums everything that

12 exists and we are very pleased that many of

13 our measures are actually strongly supported

14 by Cochrane Reviews, which is a big deal.

15   So the sealant measure is one

16 measure that is strongly supported by evidence

17 and the importance of this measure is there is

18 a huge performance gap of the community.

19   We have known about this for a

20 long time and we're still not able to see that

21 improvement go through. So this is very near

22 and dear to our hearts in terms of moving this

1   measure forward.

2   And the reason why it is based on

3   age is we want to really spend the target, the

4   resources to where it's absolutely needed.

5   It's needed in the high risk groups and there

6   is risk assessment performed, there are codes

7   available for risk, there are new codes.

8   Those codes were actually

9   implemented as part of this process so we were

10 able to influence a procedure coding system to

11 help make measurement possible.

12   We have some logic in there for

13 risk, past history of caries is one of the

14 most important and valid indicators for caries

15 risk, so we have some logic in there, it's an

16 "or" clause.

17   If you have the code for risk

18 assessment use it, if not at least go back and

19 identify the core group of kids that

20 absolutely need this intervention. So that's

21 what this measure is focused on.

22   So ages 6 to 9 aligns with the

1 eruption of the permanent molars and then we

2 have the risk logic, the tooth is permanent

3 molars, that's what the guideline says,

4 evidence is there to support that that's the

5 tooth that gets affected and, you know, you

6 have both resource and outcomes based on all

7 of that. So that's in terms of the sealant

8 measure.

9   The next concern that was

10 expressed was about the care continuity

11 measure and the evidence that's available for

12 the care continuity measure.

13   So anyone who has worked in the

14 evidence-based guidelines space will recognize

15 this very clearly as soon as you have evidence

16 presented to the panel, it really can go

17 either way unless you have strong RCTs all

18 telling you the quality, quantity, consistency

19 criteria met and everything going in one

20 direction.

21   So, again, we have Cochrane

22 Reviews, but it is a weak level of evidence

1   for this based on Cochrane Reviews which rely

2   on RCTs.

3   But then we went ahead and looked

4   for other guidelines as well to support this

5   and I'd like to quote this from the Bright

6   Future's Guideline, which is "The evidence and

7   rationale section where lack of evidence is

8   problematic in many spaces, not simply in

9   dentistry, especially when it comes to

10   screening and intervention."

11   And this is what Bright Future

12   says for these components the expert panels

13   relied in a direct approach buttressed by

14   their considerable expertise and clinical

15   experience and that's exactly what we did as

16   well.

17   So we took the evidence that's

18   there today, ran it through a consensus

19   process, as Dr. Crall mentioned, the DQA is

20   really in alliance of watershed of everything

21   that represents the dental community.

22   And everyone agreed that this is

1   something that's really important to move the

2   ball forward in terms of oral health. So

3   that's there in terms of the evidence for care

4   continuity.

5   Every other measure we have the

6   evidence listed inside the evidence testing

7   forms and that's about it in terms of, you

8   know, addressing the concerns expressed from

9   the committee.

10   Again, we'd like to thank you all

11   for your attention and for the time that you

12   gave us this morning and we'll willing to

13   answer any questions.

14   MR. CRALL: And I would just like

15   to add, I mean you can hear Krishna's evidence

16   base, she was involved in the evidence base

17   world before she came to us and the DQA.

18   The other person with us here

19   today is Dr. Jill Herndon, sitting at the

20   table here from the University of Florida,

21   Institute for Child Health Policy.

22   We awarded a contract through a

1   competitive process to the Institute to do the

2   testing of our measures. They had access to

3   data from two large States for a Medicaid

4   Program, CHIP Program, and some commercial

5   data as well.

6   And Jill and her colleagues have

7   just been an incredible asset and resource to

8   us in doing the testing which we know is very

9   important as the broaden measures movement

10 moves forward, but historically it hasn't been

11 all that robust particularly within the dental

12 measures world.

13   So Jill is here as well for if we

14 get into any technical questions about the

15 testing.

16   MS. SAMPSEL: So what we're going

17 to do know is go ahead and move into the

18 measures and what, you know, with the new

19 process of the having the developers here as

20 well as Dr. Crall, you all are also, can turn

21 this up if you have any questions through any

22 of the process, but we'll ask members to do

1   that as well.

2   But we'll go ahead and start going

3   through the measures and, Tom.

4   MR. MCINERNEY: I just want to

5   provide a little background and ask for a

6   little help in my understanding. You know,

7   we've had water fluoridation for a long, long

8   time and that certainly is a big help in

9   preventing dental caries.

10   However, it's my impression as a

11   pediatrician that water fluoridation now is

12   not as effective as it used to be for several

13   different reasons.

14   Mainly, families are not using tap

15   water that much anymore. Unfortunately, in

16   many cases they're using juice or other

17   beverages and worse yet these are often high

18   in sugars.

19   But they've turned to bottled

20   waters in huge amounts and bottled water

21   generally does not have any fluoride and so I

22   think, my suspicion is that the incidents of

1   dental caries may have hit a nadir and is now

2   on the way back up again because of this.

3   And so it makes this whole

4   business of trying to prevent dental caries

5   even more important now than it was perhaps

6   ten or 15 years ago and I just wonder if you

7   could confirm that for me please?

8   MR. CRALL: Certainly. I'll start

9   and then Krishna can add. Well, as a

10   pediatrician you're absolutely right. Your

11   reality I think confirms the broader data

12   sources.

13   Clearly data from in Haines,

14   periodic in Haines have shown us that what

15   there's an increase in for the most part is

16   what we call early childhood caries, so that's

17   tooth decay occurring in children before the

18   age of six years of age.

19   And we know that that's an

20   absolutely critical time. There is some

21   evidence from both the U.S. and from other

22   Countries to suggest that those first three to

1   five years of life are really important in

2   setting a positive health trajectory for

3   children.

4   And consistent with recent

5   guidelines, and I'll say recent meaning that

6   they're, you know, probably at least ten plus

7   years in the dental world and actually they're

8   11 years old in the pediatric world as well,

9   the AAP Guidelines, that now suggest that

10 individuals who are trained to do so should

11 start assessing caries risk in young children

12 as early as six months of age.

13   Any child found to be at high risk

14 should be referred to what we call a dental

15 home for analogous to the medical home by one

16 year of age.

17   So, again, just as with the

18 sealants, changing systems, changing provider

19 behaviors, is not easy, but by creating

20 measures and highlighting the importance of

21 things that are clearly evidence-based like

22 sealants and fluorides, absolutely we think

1 that that's the first place to start and

2 hopefully will be at least one part of the

3 continuing emphasis on that.

4   Because the fight on water

5 fluoridation is not over, the anti-

6 fluoridationists are very strong and

7 persuasive and it's a constant battle to keep

8 water fluoridation even in places that have

9 it.

10   But you're, I think you're right.

11 In the National data, again, that we have

12 dated from many States, and then within that

13 the whole issue about caries risk and we know

14 at a population level low income individuals,

15 individuals from certain races and

16 ethnicities, and recent immigrants are often

17 times the groups that are at high risk.

18   The challenge moving forward, and

19 it's a movement that we fully support is to

20 once you get beyond the population

21 characteristics that define risk, to start

22 looking individual, child by child, and to be

1   able to differentiate because not all children

2   on Medicaid are at high risk for caries, but

3   just a higher proportion than in other

4   segments of the population.

5   MR. MCINERNEY: Okay.

6   MS. ARAVAMUDHAM: Just another

7   note about water fluoridation. We were at a

8   public health conference just yesterday where

9   we talked about there is a water fluoridation

10   challenge in every one of the 50 States, every

11   single one there is some challenge.

12   Infrastructure is becoming old and

13   now the County Governments are faced with a

14   challenge of, you know, renewing the

15   infrastructure and spending money towards

16   fluoridating the water versus just letting it

17   go.

18   And so we're facing a challenge in

19   every State of this Country, so that's

20   something we are trying to address as well.

21   MR. MCINERNEY: Okay.

22   MS. SAMPSEL: So with that we'll

1   move into Measure 2508, Prevention, Dental

2   Sealants for 6 to 9 Year Old Children at

3   Elevated Caries Risk. Dr. Krol, did you want

4   to kick us off?

5   MR. KROL: Sure. So this measure

6   is a process measure focused on whether 6 to

7   9 year old children at moderate to high caries

8   risk receive a dental sealant on a first

9   permanent molar.

10   The connection between the process

11 and the health outcome is stated in the

12 following way. Timely placement of dental

13 sealants on permanent first molars have

14 demonstrated effectiveness in reducing caries,

15 dental decay, tooth decay, among children

16 thereby improving oral health, overall health,

17 and overall well-being.

18   A clinical practice guideline from

19 the American Dental Association and a Cochrane

20 Review are presented as evidence to support

21 the measure.

22   The Cochrane Review, as well as a

1 meta-analysis are used as evidence in the ADA

2 clinical practice guideline. The ADA

3 guideline does not give an age or a specific

4 molar for sealant placement, but says sealants

5 should be placed on pits and fishers of

6 children's and adolescent's permanent teeth

7 when it is determined that the tooth of the

8 patient is at risk for developing caries.

9   The strength of the recommendation

10 is graded B directly based on Category 2

11 evidence or an extrapolated recommendation for

12 Category 1 evidence.

13   The evidence upon which this

14 recommendation is based is rated as 1(a),

15 which is evidence from systematic reviews of

16 randomized controlled trials. Evidence rating

17 is high, although the age range is not clearly

18 delineated in the evidence as far as I could

19 tell, but rather based on risk level.

20   Is this how, can we just go

21 through 1(a) through like we did on the call

22 or is there a way that you'd like me to do

1   this any differently?

2   MS. SAMPSEL: I guess if others on

3   the call have anything to add to 1(a) or if

4   there's discussion about that. Okay?

5   MR. KROL: Okay.

6   MS. SAMPSEL: Proceed.

7   MR. KROL: Okay. 1(b),

8   performance gap, data are made available that

9   demonstrates a variation in performance of

10   dental sealant placement on children ages 6 to

11   9. It's not clear how the risk status of the

12   6 to 9 year olds was documented or applied to

13   the numerator and denominator.

14   It's also not clear how many first

15   permanent molars are sealed. Presumably, a

16   child with four first molars with one sealed

17   was qualified as much as a child with four

18   molars and four sealants and one molar and one

19   sealant, et cetera.

20   There are also data that support

21   the existence of disparities by age, race,

22   ethnicity, geographic area, and family income.

1   So I rated that as a high rated choice. Shall

2   I stop there or go onto 1(c) and should I just

3   continue through or what would you prefer?

4   MS. SAMPSEL: I think Jason may

5   have a comment.

6   MR. SPANGLER: I have a process

7   question. Are we going to be voting on these

8   each at a time? Because I know I've done this

9   before, we voted on evidence and then we voted

10 on performance GAP and then we voted on

11 importance and stuff like that or are we --

12   MS. SAMPSEL: We're going to go

13 through the full discussion first.

14   MR. SPANGLER: Okay.

15   MS. SAMPSEL: So that's, it is a

16 good question. So we'll have each member of

17 the committee deal with your assigned measure,

18 is go through the discussion bringing up the

19 salient points for each of the high level

20 variables of, you know, whether it's the

21 importance to measure and report, feasibility,

22 et cetera.

1   We'll have a full discussion with

2   the opportunity for the developers to answer

3   any questions, to offer any clarification, and

4   then we'll go through and vote on each area

5   because there are some areas that, you know,

6   they are must pass elements and we won't go

7   any further if the measure doesn't meet those

8   must pass elements.

9   So, you know, just bring up the

10   highlights for any specific measure and then

11   we'll have discussion.

12   MR. KROL: Okay. So as far as

13   high priority the data are made available for

14   the percentage of children who have dental

15   disease.

16   The ADA previous reported on

17   higher disease rates in certain populations,

18   i.e, minority populations and poor

19   populations, and the disease is noted as the

20   utmost common chronic disease of childhood.

21   So let's move to reliability and

22   all that, so 2(a)(1) and 2(b)(1)

1   specifications. So the information provided

2   regarding the numerator and the denominator

3   with respect to age and dental service code

4   per sealant and per tooth upon which it was

5   placed well define each.

6   We talked about this on the call

7   and I'll bring this up if you feel it's

8   appropriate, but please stop me if you don't

9   think it is.

10   So what's not clear is the

11   definition of elevated risk, is there's a very

12   large number of CDT codes to determine that.

13   Now it was addressed on here so I'm not sure

14   if you want me to go into all that.

15   Not knowing what those stand for

16   and not knowing how that array of CDT codes is

17   seen as an accurate definition of elevated

18   risk it's hard to determine the quality of the

19   measure.

20   It's also not clear to me how a

21   child with one of four teeth sealed is of

22   equal quality to one who is two of four or

1 four of four and does not see it possible to

2 determine that with this measure.

3   Is the child at elevated risk, or

4 the tooth, or both, and can a tooth be at risk

5 but not a child? How does one determine that

6 here or is that not important?

7   One of the evidence sources,

8 Beauchamp, gives either as the determination

9 of risk, so it's either child or tooth. So I

10 had some concerns about the consistent

11 implementation of the definition of risk

12 status.

13   What doesn't quite make sense

14 also, and this is a separate issue, is how the

15 service is provided by and independent dental

16 hygienist as coded in the numerator?

17   The logic states that if the

18 rendering provider taxonomy code equals any of

19 those listed in Table 1 then include them in

20 the numerator. If there is one code listed

21 that wouldn't qualify but has a notation that

22 states it is not applicable for this measure.

1   So that one didn't quite make

2   sense and that was somewhat addressed in the

3   presentation. Reliability testing, not done

4   using statistical tests with the measure as

5   specified.

6   The authors though do make a case

7   that the measure relies on standard data

8   fields commonly used in administrative data

9   and that inter-rater reliability doesn't

10   apply.

11   Yes, I can skip some of that to

12   move more quickly. Why don't I go to validity

13   testing. So the validity testing for this

14   measure assessed critical data element

15   validity, measures score validity, and

16   potential threats to validity.

17   All of that seemed to be well

18   done. I had no concerns about that. No

19   issues for any of the other 2(b)'s. Addressed

20   missing data although there was some

21   discussion on our call about the exclusions.

22   I don't know if anybody wants to

1   bring that up at this point. That was

2   addressed a bit and the willingness to change

3   the language. I know, Bob, you had brought

4   that up on the call previously.

5   MR. VALDEZ: Yes. Yes, I brought

6   that up on the call and it affects all of the

7   dental measures and as part of the

8   presentation and certainly in the presentation

9   they made clear the intent of what they wanted

10 to say much better than what they put in this

11 document.

12   I don't know how you handle that,

13 whether it's an amendment that they do?

14 Because I think they were asking that on the

15 call as well.

16   MS. KHAN: So just one

17 housekeeping thing. There can only be three

18 mikes on at a time so if someone has it on

19 just turn it off when you're done speaking.

20   But what we can do is after the

21 in-person meeting we can reopen their forums

22 and they can clarify whatever it is that needs

1   clarification in the forum.

2   MR. KROL: Sorry. Do you want me

3   to continue?

4   MS. SAMPSEL: Yes.

5   MR. KROL: So Criterion 3,

6   feasibility, the overall rating was high

7   there. These are administrative data so as

8   long as someone decides to bill for the

9   service then it'll be accurate.

10   As far as usability and use, it's

11   right now currently used in Texas for their

12   Medicaid and CHIP Programs, also being

13   suggested for use in Connecticut.

14   It's not quite yet, it's not yet

15   clear evidence that it's being shown to

16   improve care or quality, but likely too early

17   as it's just been implemented in Texas, but

18   that was addressed previously. And I guess

19   that's it.

20   MS. SAMPSEL: Okay, so let's go

21   back up a little bit to the top and talk

22   briefly about importance and see if anybody

1   had any questions or additional comments or if

2   there was anything that the DQA wanted to

3   address in that area.

4   MR. BIALEK: A question about one

5   of the comments from the workgroup regarding

6   the data, and there was a comment that if the

7   sealant was applied by a dental hygienist it

8   wasn't captured and then I think the response

9   back was well, yes, it is, but I wasn't sure?

10   MS. ARAVAMUDHAN: It is captured.

11   So the other codes that are listed within the

12   spec sheet, each of those spec sheets

13   references a user guide. We did not put that

14   in the appendix, we should have.

15   But the user guide specifically

16   describes each of the codes and it is captured

17   in the numerator.

18   MR. VALDEZ: This is Robert

19   Valdez.

20   MS. ARAVAMUDHAN: Go ahead.

21   MR. VALDEZ: Were you referring to

22   the exclusion of the provider specific piece

1   or the hygienist that was under the direct

2   supervision of a dentist?

3   MR. BIALEK: I was just referring

4   to whether or not the child received the

5   sealant, didn't matter really who applied it.

6   And I was, the bulleted point in here looked

7   like it might be excluded if it was applied by

8   the hygienist and the response was well, it's

9   not. It doesn't matter who applies it that

10   it's captured.

11   MS. ARAVAMUDHAN: So the way the

12   dentist services again works is anything

13   that's done or under the supervision, and most

14   of the State Practice Acts have either direct

15   or remote supervision.

16   Any kind of remote supervision,

17   anything would fall under the dental services

18   and that would be captured.

19   MS. SAMPSEL: John, did you have a

20   question?

21   MR. AUERBACH: My question was

22   about numerator and denominator and, you know,

1 in part, and maybe you can speak to the

2 coverage issue and I know in many States oral

3 health coverage changes quite regularly in

4 terms of coverage.

5   And also, so just in terms of

6 that, just the, you know, your comfort level

7 with variations in terms of coverage and

8 therefore presumably reporting, and I don't

9 know whether for instance public health

10 programs sometimes provide sealant programs

11 but may not be reporting those in ways that

12 can be captured.

13   And then just on the third part of

14 that, is just the size of the population that

15 may not be say Medicaid eligible are

16 considered to be a moderate to high risk?

17   MR. CRALL: Let me start with that

18 and then let Krishna add. So I think the key

19 phrase that David used was if somebody submits

20 a claim and it's billable, because that is the

21 primary data source for this and that does

22 capture the vast majority of all the services

1 that were provided.

2   I think, you know, your point is

3 right. If for some reason somebody had a,

4 let's say a grant funded program in the

5 community and they had someone that the State

6 laws allowed to provide those sealants, that

7 wouldn't necessarily be captured here because

8 this comes through claims data.

9   But, again, you know, the evidence

10 we have is that the vast majority of services

11 are captured in this mechanism and we didn't

12 get into the, sort of the weeds about direct

13 supervision or any of those things.

14   If it's allowed, if that practice

15 and setting is allowed in any State then

16 that's what should be captured in the measure.

17   MS. ARAVAMUDHAN: If I might add

18 on to that. I was very enamored with the

19 discussion this morning in terms of, you know,

20 all of the different types and population

21 health.

22   I think what our strategy is to

1   look, I don't know whether this is a right

2   term, but a family of measures, if you will,

3   where the concept focuses we need to get the

4   sealant rate up. That's the goal.

5   And then you have okay, here is a

6   measure that applies to the plan and here is

7   the measure that apply to another because the

8   attribution is different, the my patients is

9   different for each of these groups.

10   And so then you work on each of

11 your parts in the healthcare delivery system

12 and then all of your targeted National goal of

13 improving sealants.

14   So the mechanics of the measure

15 will be different for each of these

16 components, but all of you are going towards

17 that goal. So these measures simply address

18 the program and the plan level.

19   And then you'll have other similar

20 kind of components adding on. So, yes, I

21 think we answered two of your questions, we

22 may not have answered one, but I forgot which

1 one that was.

2   MR. AUERBACH: The size of the

3 population that may fall into the risk

4 category --

5   MS. ARAVAMUDHAN: Yes.

6   MR. AUERBACH: -- but may not be

7 captured because of Medicaid or insurance

8 coverage.

9   MS. ARAVAMUDHAN: So the way the

10 risk logic, there are two things to this.

11 There was a lot of churn, I think you're

12 referring to the churn in Medicaid with oral

13 health where people come in and go out.

14   And that was a huge concern for us

15 and the way we -- And there's a lot of debate

16 in the oral health community as how to address

17 this churn, whether the program plan should be

18 accountable for everyone who's in the program,

19 even for 90 days, versus only accountable for

20 those who are in the program for 11 out of 12

21 months.

22   Those are two extremes. And you

1   go to the 11 out of 12 months enrollment you

2   see that you lose two-thirds of the children

3   in some of the programs.

4   So then is fair to simply hold the

5   program accountable for that few kids that are

6   there with them? And then the 90 days is it

7   simply not sufficient for the patient to

8   navigate the healthcare system.

9   It's ideal, but it's simply not

10   possible to navigate the healthcare system,

11   get the insurance card, make the appointment,

12   get your needed care and then come to the

13   prevention end.

14   So the measure testing has a lot

15   of data where we looked at different types of

16   enrollment periods and we picked the 180 which

17   balances the need to account for enough

18   children while at the same time giving enough

19   time to actually make this a reasonable,

20   realistic measure. So we did that to include.

21   In terms of we're at risk status,

22   again, we have new procedure codes that come

1   through the claim system in terms of recording

2   high, moderate, and low risk, so it's an

3   individual based risk.

4   As Dr. Crall mentioned the

5   traditional method would have been everyone in

6   Medicaid is high risk, but then we don't want

7   that. We heard from many Medicaid directors,

8   that, look, we're in a stage where we really

9   need to target our resources and give the kids

10   that absolutely need this, make sure they get

11   it.

12   And so they were like individual

13   leveled risk assessment is very, very

14   important. So that's why we have the new

15   codes that help the provider capture risks and

16   then transmit it upwards and also we have the

17   backup plan of, you know, looking past

18   history.

19   Enrollment is not required in the

20   past. As long as you have the data you can

21   capture that.

22   MR. CRALL: And if I may, I

1   actually heard a little different, I had a

2   little different take on your question. So in

3   adult Medicaid, clearly, there is what you

4   might you refer to as variation.

5   It's not a required service.

6   States get pressed for fiscal, you know,

7   financial sort of reasons and they drop it,

8   California dropped adult Medicaid, you know,

9   three, four years later we're putting back in

10   some benefits, so that does vary quite a bit.

11   The kids piece is EPSDT. Sealants

12   are clearly sort of outlined as a necessary

13   service, so there's good evidence for it and

14   so, you know, while some States might look to

15   things to like evidence-based guidelines and

16   revisions of evidence-based guidelines which

17   are done maybe every five to ten years and

18   modify their conditions of medical necessity

19   accordingly.

20   By and large you're not seeing

21   sort of any quibbling about whether or not

22   sealants are a covered service in a Medicaid

1   program.

2   And I can just say in terms of the

3   extent of the covered population in this year,

4   in my State of California, 51 percent of the

5   kids are on Medicaid.

6   So with the ACA and other

7   expansions of States and then entertaining, so

8   by the time you add the commercial piece on

9   that we typically have lagged, coverage has

10 lagged for dental services compared to medical

11 services.

12   We used to say for every child

13 that lacked medical insurance or health

14 insurance, as it's generally referred to,

15 there were 2.6 kids who lacked dental

16 insurance.

17   But that gap is being closed

18 through a variety of recent legislation and

19 State actions and changes in eligibility, so

20 it's a shrinking population. We capture the

21 majority of kids through public programs plus

22 the commercial sector, employer sponsored

1   piece that comes along on top of that.

2   But there's still a segment of

3   kids who are not eligible for any coverage,

4   that's a challenge regardless of what measure

5   you're trying to implement I think.

6   MS. SAMPSEL: Yes, before we do

7   anymore questions diving further down in the

8   criteria I want to bring everybody back to the

9   evidence section and Criterion 1.

10   And what we're going to start

11   doing and we'll ask Kaitlynn to help us with

12   a dry run is go ahead and go back to the

13   evidence section and do the initial vote on

14   number one importance to measure and report.

15   But before we do that, you know,

16   again, any questions, comments, anything else

17   anybody wanted clarified on the impact of this

18   measure?

19   MS. MUNTHALI: And I just want to

20   add that the criterion and sub-criteria within

21   importance to measure and report are must

22   pass, and so if you have any points of

1   clarification for DQA I would recommend that

2   you ask them now.

3   MS. LUCK: Hi. I was wondering if

4   you could walk us through the

5   operationalization of the elevated risk factor

6   in the numerator and denominator? How is that

7   operationalized in measuring this measure?

8   Thank you.

9   MS. ARAVAMUDHAN: So, again, the

10   way that it's operationalized is there are

11   three CDT codes, the procedure codes. Since

12   the dental system does not report diagnostic

13   coding we sort of went a roundabout way to get

14   CDT codes in place to capture risks.

15   So 0601, 0602, 0603, are low,

16   medium, and high.

17   MR. CRALL: Caries risk.

18   MS. ARAVAMUDHAN: Caries risk.

19   MR. CRALL: The designation of

20   caries risk on the part of the clinician.

21   MS. ARAVAMUDHAN: Caries risk.

22   Right. It's a descriptor of risk assessment

1   performed, finding of low risk, risk

2   assessment performed, finding of moderate

3   risk, risk assessment performed, finding of

4   high risk.

5   So when you have the two codes of

6   02 and 03 reported that is flagged as yes,

7   this is a person that's moderate or high and

8   should become part of this measure.

9   Now in cases where you don't have

10 the risk, when the systems are still gearing

11 up towards that risk assessment then we have

12 this place where that you can look back for

13 three years and see whether the child has

14 received restorations and all those, I know we

15 only have the codes listed and those codes are

16 simply restoration codes and pulp therapy

17 codes.

18   So if you have any of those

19 treatments done they are simply indicative

20 that you've had the disease and that is in any

21 amount of literature you see past history is

22 the most important valid predictor of future

1   disease.

2   So you want to be able to prevent.

3   So in cases that you've had any kind of

4   restorations then you would pick up the case

5   as well.

6   MR. CRALL: And I would just add

7   that one of the benefits of having Jill and

8   her team involved in the testing of these

9   measures is that we were actually able and we

10   put them through many iterations of well, what

11   if we use this set of codes versus what if we

12   use that set codes?

13   And so we could actually look and

14   see what the results were across different

15   States and different covered populations

16   within those States, whether or not you, you

17   know, the codes, and I apologize that those

18   explanations for those current codes aren't in

19   there because everybody, those numbers unless

20   you live in that world, but as Krishna said

21   they were indicative that the child had

22   already had some restorative care or treatment

1 for the, what we call the pulp, the inner

2 portion of the tooth where the nerves and the

3 blood vessels are.

4   And we took our guide to some

5 degree in that from members of our Measures,

6 Development, and Maintenance Committee,

7 several of whom basically have a background or

8 experience working with plans, dental plans,

9 and one in particular has had experience

10 working in the largest benefit plan for kids

11 that are covered in Medicaid.

12   So, you know, they in fact use

13 similar types of procedures but we did the

14 testing again through the Institute of Child

15 Health Policy on those two State data sets to

16 see what the results would be.

17   And one last point that David

18 brought up is that, and he's right, you know.

19 If we had our way we would have every child's

20 teeth sealed, you know, early before they got

21 decay early on.

22   The problem you encounter in

1 trying to develop a measure to capture it is

2 that without the, you know, longitudinal

3 history of the child from birth onwards you

4 may not be able to tell even which teeth are

5 yet unsealed and therefore candidates for

6 sealant versus not.

7 But we, and Krishna will probably

8 have a better grasp on the details of this,

9 but even in our testing we found that if we

10 look and a child only had one sealant there's

11 still a performance gap around that.

12 So it won't be the perfect

13 measure, it won't be the end all measure, but

14 we think it's a good place to start.

15 MS. SAMPSEL: Arjun, did you have

16 a question?

17 MR. VENKATESH: I think they're

18 more related in measureabilities, that would

19 be later, right?

20 MS. SAMPSEL: Okay, thank you.

21 MR. BAER: Question? Sorry. Yes,

22 question on the three risk codes. Is there a

1 validated screening tool?

2   MR. CRALL: I would say that the

3 evidence for the validation of that is not

4 robust simply because there are new codes that

5 are being implemented.

6   The description suggests the, or

7 the descriptor on the CDC code would point to

8 the use of code, excuse me, risk assessment

9 tools such as one that's called CAMBRA, which

10 is Caries Management by Risk Assessment, been

11 developed out of the University of California,

12 San Francisco, and widely used more on the

13 Western part of the Country.

14   The American Academy of Pediatric

15 Dentistry has a tool, the ADA has a tool, the

16 evidence on the validation sort of part of

17 those is not robust because it's basically a

18 new phenomenon.

19   It really came almost online as we

20 were developing these measures and that's why

21 we incorporated them into the approach for

22 assessing risk.

1   MS. ASOMUGHA: We can we still ask

2   questions about measure sets? Ask questions

3   about measure sets or not?

4   MS. SAMPSEL: We're going to --

5   MS. ASOMUGHA: Okay.

6   MS. SAMPSEL: Let's focus on

7   importance right now so we can start moving

8   towards the vote. Any other questions on

9   importance? Okay, Kaitlynn?

10   MS. ROBINSON-ECTOR: Okay. Yes,

11   so just to vote make sure that your clicker is

12   pointing toward the vote snap, towards me.

13   And we're actually going to go

14   ahead and read off the questions, so high

15   impact is addressing a specific National

16   health goal, priority, or data demonstrated,

17   a high impact aspect of healthcare, so the

18   numbers affected, resource use, and the

19   severity in consequences.

20   So if you agree that the measure

21   has a high impact please press one, if you

22   think it's moderate press two, if it's low

```
 1    then press three, and four for insufficient

 2    evidence.

 3              The slides in the front are the

 4    voting slides so that has the details on what

 5    you're voting on.

 6              MS. SAMPSEL:  Okay.  Has everyone

 7    voted?

 8              (Off microphone discussion)

 9              MS. SAMPSEL:  Okay.  Now I think

10    everybody can vote.

11              MS. ROBINSON-ECTOR:  How many

12    people are we waiting -- Good.

13              MR. FRANCE:  Just to clarify how

14    these work, push the button once that's it, or

15    do you hit the send button at the bottom after

16    you do it?

17              MS. ROBINSON-ECTOR:  No, you don't

18    need to hit send, just press your button.

19    We're trying to get to 21 votes.

20              MS. SAMPSEL:  Yes, we're at 21.

21              MS. ROBINSON-ECTOR:  Okay.

22              MS. MUNTHALI:  And, Kaitlynn, can
```

1   you just clarify, is this the test or is the

2   actual vote on the measure?

3   MS. ROBINSON-ECTOR: This is the

4   actual vote.

5   MS. MUNTHALI: Okay.

6   MS. ROBINSON-ECTOR: But we can

7   redo it.

8   MS. MUNTHALI: No, it looks like

9   everybody's device is working.

10   MS. ROBINSON-ECTOR: Okay. Okay,

11   so for --

12   MS. MUNTHALI: So just to clarify

13   that means we'll move over to 1(b)?

14   MS. SAMPSEL: Yes.

15   MS. ROBINSON-ECTOR: Yes. Well we

16   are setting it off.

17   MS. SAMPSEL: Wait, we have to

18   announce the vote for 1(a).

19   MS. ROBINSON-ECTOR: So for 1(a)

20   we have 15 voted for high, 5 voted for

21   moderate, and 1 voted for low.

22   MS. NISHIMI: I just want to

1   clarify for the committee why we have to do

2   all this announcing, because there is a

3   transcript and people on the phone also can't

4   see, obviously, the screen, so that's why you

5   might think it's a little bit cumbersome, but

6   there's a reason we're doing it.

7   MS. ROBINSON-ECTOR: So 1(c) is

8   for evidence for measures of health outcome,

9   is there a rationale/causal path that supports

10 the relationship of the health outcome, do

11 processes or structures appear? One for yes,

12 two for no. Okay, and --

13   MR. KROL: Was 1(a) and 1(b)

14 combined? We skipped 1(b)?

15   MS. ROBINSON-ECTOR: No. So the

16 order it goes in is we're looking at high

17 impact and then we're looking at evidence and

18 then we're looking at performance gap.

19   MS. KHAN: Okay, so --

20   MS. ROBINSON-ECTOR: And it's

21 actually, it's a 1(c) evidence for a process

22 measure, so it's the next. I'm sorry.

1   MS. KHAN: Yes, okay.

2   MS. ROBINSON-ECTOR: So this is

3   1(c) evidence structure process, intermediate

4   outcome. Based on the information submitted

5   quantity and quality and consistency of body

6   of evidence are met as follows, consistency,

7   moderate or high, quantity and quality,

8   moderate or high, or low with special

9   circumstances.

10   One is yes, two is no, evidence

11   does not meet guidance, three is no,

12   insufficient information submitted. So I'm

13   going to click the timer for 60 seconds.

14   (Pause)

15   MS. ROBINSON-ECTOR: Still waiting

16   for one more.

17   (Pause)

18   MS. ROBINSON-ECTOR: Okay. So for

19   1(c) we had 21 votes for yes.

20   (Pause)

21   MS. ROBINSON-ECTOR: Oh, 20.

22   Okay, so 1(b), importance to measure and

1   report. 1(b), performance gap, data

2   demonstrated considerable variation or overall

3   less than optimal performance across providers

4   and/or population groups.

5   One is high, two is moderate,

6   three is low, four is insufficient evidence.

7   (Pause)

8   MS. ROBINSON-ECTOR: I think we're

9   still waiting for one vote.

10   (Pause)

11   MS. ROBINSON-ECTOR: If you all

12 could just press it one more time, please.

13 Okay, great, there we go. Okay. Okay, so we

14 had 12 for high, eight for moderate and one

15 for low.

16   MS. SAMPSEL: Okay. So before we

17 move into this next area of voting this would

18 be any questions on the specifications

19 specifically. Go ahead.

20   MR. VENKATESH: So I had I guess a

21 series of questions around the validity of a

22 claims-based measure and then another question

1   around the level of analysis, which may be

2   more of a question for NQF.

3   Around the claims-based measure I

4   think a little education for me may even help,

5   which is that are these measures all assigned

6   by the qualified provider?

7   And then when the claim, when it's

8   coded are these codes that you guys eluded to

9   the three codes, these CDT codes, do those

10   function like g codes do for physicians where

11   they're optional or are they required in the

12   coding of each claim?

13   MS. ARAVAMUDHAN: Okay. I'm going

14   to try to answer, but I'm going to actually

15   request Dr. Inge to chime in as well. He

16   might have a better sense of this.

17   So the coding is by, so the first

18   questions was the claims coming in by

19   provider. So there are different ways in

20   which the program, so standalone dental plans

21   as we showed in the data, 99 percent are just

22   dental, and we do have a footnote and the user

1   guide simply states that standalone dental

2   plans ignore this whole provider filter.

3   You don't even need it. Simply,

4   all your claims process it. It's only when

5   you're using this measure at the program level

6   that this whole provider thing and the filter

7   comes into play.

8   And in those cases many programs

9   maintain separate filing systems, so you don't

10   have to even use the logic, they can use the

11   filing system and say okay, here are all the

12   dental services and it goes that way.

13   So it really depends, and we have

14   more information in the user guide how to

15   apply that and when to apply that. In terms

16   of whether the codes itself are required or

17   not required, we really want to, part of the

18   quality improvement effort through this

19   process is not simply to improve the sealant

20   rates, but also to move this concept of risk

21   based care into the community.

22   And that's really, really

1   important to us. And so measuring this at the

2   program level and the plan level hopefully the

3   plans will start requiring this. We are still

4   working to set frequencies and how often it

5   should be done.

6   So this is all hopefully will

7   evolve and use of implementation of this

8   measure will actually push the system in this

9   direction.

10   MR. CRALL: So I would just say I

11   think, you know, the short answer to this is

12   these are new codes and the ability to require

13   that that field be filled out or not may vary

14   by program, but at the current time I would

15   suspect that the vast majority, it's an

16   optional entry not a required entry but Dr.

17   Inge or other, you know, may have more insight

18   in that.

19   MS. ARAVAMUDHAN: And if I can

20   just take a moment to add on, and that's why

21   we have the other filter of the past history.

22   MR. INGE: So in regards to the

1   codes being required, they are required for

2   reimbursement. So that if there's any program

3   in which a dentist or any other healthcare

4   provider wishes to be reimbursed for those

5   services then it will be required.

6   It's not optional. There were

7   some codes previously in the CDT that were

8   supposed to be applied only at moderate at

9   high risk, but we had no risk codes to

10   associate with them, and so these codes help

11   to add to that and allow us to reimburse for

12   codes based upon risk that we now have risk

13   codes.

14   So there is not an optional use of

15   those codes. Whenever they are used it's for

16   a specific purpose of defining the risk

17   category of the patient.

18   MR. CRALL: So if I could just

19   clarify my comment on optional. I meant that

20   if a clinician were to bill for a sealant I

21   think it's, in most plans today, it's optional

22   whether or not they include the risk, that's

1 what I meant.

2   So what Ron is I think eluding to

3 is that if a provider, and if any plan

4 provider that asks for reimbursement and for

5 the assessment, obviously the provider would

6 have to enter a code to register that they

7 performed the service and then if there was

8 reimbursement they would be compensated.

9   MR. VENKATESH: So just help me

10 kind of summarize that for the group in

11 understanding. Does that mean that even

12 though it is technically optional we would

13 still be capturing, the denominator would

14 capture the universe of sealant being used?

15   MR. CRALL: I think, you will

16 capture the sealants being used. What will

17 I'm sure start slowly and then depending upon

18 whatever incentives might be built into the

19 reimbursement side of things or performance or

20 any other sort of motivation for a clinician

21 to enter the risk code on top of that sealant

22 code then the capturing of the risk is

1   probably low now because of the newness of the

2   measures and it will increase over time.

3   But the capturing of the sealant

4   itself I think is basically going to occur as,

5   you know, regardless.

6   MR. VENKATESH: Okay. So then

7   would it be safe then to say that initially in

8   the use of this measure that the denominator

9   and the population being measured is going to

10   be largely those that have a prior history as

11   they capture as opposed to the risk code?

12   MR. CRALL: I would think that it

13   would be a fair assumption and, again, Jill,

14   you know, did the testing on the data that

15   existed within those States and we have

16   results form that, so that, clearly, that's

17   the mechanism that prior to the introduction

18   of these risk assessment codes you had to

19   develop some sort of a, you know, you could

20   call it a proxy measure of risk or some sort

21   of an algorithm that led you to believe that

22   that child actually had the disease process in

1   the absence of a diagnostic code that enters

2   it.

3   So, yes, I would think certainly

4   early on that the majority of them are going

5   to be captured that way.

6   MR. VENKATESH: All right. Last

7   question I promise related to that. So then

8   do you guys have any validation data that

9   suggests that coding is consistent between

10   providers? That risk assessment is validly

11   represented by the administrative code?

12   MR. CRALL: The data we have for,

13   on the actual use of those three codes would

14   be meager at this point in time because those

15   codes are just being introduced, you know,

16   into the systems.

17   What we do have are data that

18   demonstrate that using the prior experience

19   and that set of codes that David eluded to

20   actually captures information and we have that

21   at the program level and we have it for plans.

22   And that's really been the

1   essential focus of the DQA up to this point in

2   its history. We haven't moved on to that

3   provider level piece yet.

4   MR. INGE: Just a comment.

5   Request and stimulated thought from me, in

6   that with this measure it should require that

7   the risk assessment code accompany the sealant

8   code because currently we have sealants being

9   applied to very low risk populations and that

10 could distort the numbers.

11   So with this measure and the

12 subsequent measure having the risk assessment

13 code be required to accompany the sealant code

14 I think would give us a better view of its

15 effectiveness.

16   MR. FRANCE: I guess I would just

17 maybe disagree and say that there's also the

18 bias that, as a dentist I might say, I must

19 code risk with each sealant out of pride in

20 order to be paid for it.

21   And so over time 98 percent of

22 high risk are receiving sealants and so I'm

1 curious about your thoughts about how that

2 distortion of the data over time might make it

3 difficult for you to use it as a performance

4 improvement metric when billing and

5 performance might be very strongly linked.

6 MR. CRALL: Well I, you know, to

7 your point, I think that it wouldn't be the

8 first case in which that there were some sort

9 of suggestion that that might be happening,

10 right.

11 And so that's the ongoing

12 challenge in terms of designing the program or

13 the benefit plan, or the benefit structure

14 within the program to find a way whereby we

15 could actually demonstrate that the kids who

16 are designated as high risk actually are at

17 high risk.

18 There will be some subjectivity in

19 this. This is not, you know, the measurements

20 that you typically have for diabetes where you

21 have a biological marker where you can read

22 out a number on a scale.

1   It's a multi-factorial chronic

2   disease where you have a variety, you have

3   clinical factors, you have other types of

4   factors that come into play in the assessment

5   of risk.

6   It is not physics, it's healthcare

7   for humans and therefore there's going to be

8   some variation in terms of how providers code

9   it. To Ron's comment, again, even within low

10   risk populations there may be high risk

11   individuals.

12   Well off kids still get caries.

13   So the question about, you know, would you

14   actually capture risk and what's the validity

15   of that in a high risk population is, I would

16   say, a to be determined.

17   But it will come about, I believe

18   our job is to design the measure as best we

19   can under the available data and the

20   circumstances. After that it's the

21   interaction of the program design, the

22   reimbursement structure and all of that is

1   going to determine how the numbers go.

2   But your point I think is clearly

3   a valid one and, you know, I think as in many

4   other areas of health services research there

5   may be a few people who seriously try to game

6   a system.

7   I think the vast majority probably

8   try to use the codes if they're educated will

9   in a consistent way, but it's going to be that

10   interaction of benefit design reimbursement

11   and clinical practice that's going to

12   ultimately determine what the performance is.

13   MS. ARAVAMUDHAN: I would like to

14   add one thing to the previous comment.

15   MS. SAMPSEL: Oh, sure, go ahead.

16   MS. ARAVAMUDHAN: So one thing to

17   point out is for the commercial sector it's

18   not really dental insurance, it is really a

19   dental benefit.

20   There is an annual maximum and

21   after that the plan does not pay. Typically

22   benefit plans pay 100 percent for

1 preventative, but then they come down to 80 or

2 even 50 percent for restoratives and there's

3 a lot of out of pocket expense for the

4 patient.

5   So there's a lot going on on the

6 benefit side versus Medicaid. And in terms of

7 requiring these codes obviously as measure

8 developers and DQA we cannot mandate that.

9 It's something that the plans and payers

10 programs have to do.

11   What would skew the data is if the

12 benefit design at the population level simply

13 limits risk and does not allow that provider

14 judgement to come through to actually get at

15 the individual risk.

16   That's not happening today and

17 hopefully we will have mechanisms to capture

18 individual risk from the provider level

19 upwards to influence what gets treated.

20   MS. SAMPSEL: Okay. If no other

21 questions we'll move -- Oh, sorry. Ron, go

22 ahead.

1   MR. BIALEK: I may have missed

2   this. I was trying to read through the

3   document and understand it a little bit

4   better.

5   The risk assessment, if the child

6   never accesses the system is the child in the

7   data as at risk or no? So, it's no, okay.

8   So then the question if those who

9   never access the system are excluded from the

10   measure then aren't you potentially masking

11   the potential increase disparities, sort of

12   cherry pick those who access the system, apply

13   sealants, and those who never access who could

14   be the majority within the Medicaid Program or

15   the CHIP Program are never seen and never had

16   sealants applied?

17   MS. ARAVAMUDHAN: So if I can

18   respond to that first. It's like we really

19   believe that there is no one magic measure and

20   one magic score.

21   There is a picture that needs to

22   built and there are many puzzles to that

1   picture. So that's why when you saw the list

2   of measures we developed it's more did you get

3   the patient linked to care?

4   Was the patient diagnosed? Was

5   the patient prevented? Was the patient

6   treated? And then did you get that patient

7   healthy? So you need to have that framework

8   and a set of measures that follows the patient

9   through the healthcare delivery system in

10   order to see whether, you know, you improved

11   your population health.

12   So this is one piece of the

13   puzzle. We have the oral evaluation and the

14   utilization that target exactly what you said,

15   did we get the people into the system?

16   So we really want to see that

17   measure go up and as that measure goes up this

18   is sort of okay, now, did we get the

19   prevention done?

20   So there are many pieces to this

21   that, you know, there's no one magic measure

22   and that comment will hopefully be addressed

1   through another measure.

2   MR. CRALL: Yes, and I would just

3   add, you know, so if we were trying to use

4   this measure as an indicator of the

5   epidemiology of the disease in these molars

6   then I think there might be some very serious

7   concerns.

8   But if we're dealing with it

9   within a context of accountability, so a

10   Medicaid Program basically has a set of

11   enrolled individuals, they have a certain set

12   of requirements that flow from that, States

13   have used a variety of ways to try to modify

14   utilization based on those responsibilities.

15   They'll contract with plans. They

16   may use incentives. I mean CMS has an oral

17   health initiative right now that is basically

18   asking all the States to increase the number

19   of kids who get sealants by 10 percentage

20   points above where there are now.

21   So, you know, States that

22   administer their own programs will develop

1   their own incentives for doing that. States

2   that contract out with plans will try to

3   provide, you know, some other mechanism so

4   that the plans will be able to differentiate

5   themselves and to demonstrate increases in

6   performance.

7   But that's where the

8   accountability piece lies and where it stops.

9   It's not meant to be an epidemiological

10   indicator, it's meant to be something that

11   helps you demonstrate whether or not there was

12   a change in performance at the program or plan

13   level.

14   MS. ARAVAMUDHAN: And one more

15   thing is, as the program administrator looks

16   at the score and says okay, why am I doing so

17   badly?

18   They'll go and look at am I not

19   getting the kids into the chair, or the kids

20   that are coming into the chair are not getting

21   the service.

22   So there's more than access and

1 process components to the measures score when

2 the denominator is all enrollees, so hopefully

3 we can dig into the data that way.

4   The original DQA measures have

5 something called Denominator 1 and Denominator

6 2 where Denominator 1 is all enrollees and

7 Denominator 2 is utilizers.

8   And when you see the differential

9 you can see sometimes services are 90 percent

10 at the process level, so those who come to the

11 chair get it, but it's an access problem. So

12 people need to dig into the data to figure out

13 why it is.

14   MS. SAMPSEL: Okay. With no other

15 questions we'll turn it over to Kaitlynn and

16 just to go through the process one more time,

17 Kaitlynn's going to read the criterion that

18 we're voting on, provide the options for

19 answers and which buttons you would need to

20 push.

21   We will direct our buttons towards

22 Kaitlynn as well as she will then click on

1   that little thing in the right hand corner of

2   the front screen that starts the timer and we

3   just all have one minute to get our vote to

4   Kaitlynn. So with that, Kaitlynn.

5   MS. ROBINSON-ECTOR: Okay. So

6   2(a), reliability including 2(a)(1), precise

7   specifications and 2(a)(2), testing

8   appropriate methods and scope with adequate

9   results.

10   For high press button one, for

11   moderate press button two, for low press

12   button three, for insufficient evidence press

13   button four, and time begins now.

14   (Pause)

15   MS. ROBINSON-ECTOR: Okay. So we

16   now have all 21 votes and voting will close

17   now. Okay, we had three votes for high, 12

18   votes for moderate, one vote for low, and five

19   votes for insufficient.

20   MS. SAMPSEL: All right, can we

21   hold on a second? Emilio, you had a question?

22   MR. CARILLO: Can we review the

1 algorithm for insufficient in terms of

2 exempted, not exempted?

3 　　　　　MS. KHAN: Sure. Everyone has a

4 copy at their desk.

5 　　　　　MR. CARILLO: Because whether

6 people vote for that or not depends on

7 understanding the full intent of that.

8 　　　　　MS. KHAN: Sure. So we're looking

9 at reliability right now. The algorithm is

10 the third page, it says 15 on the bottom. So

11 when we want to rate something inefficient

12 we're actually, if you start at, let's see,

13 well I guess maybe Elisa you should, you're

14 the methods person.

15 　　　　　MS. MUNTHALI: You guess. Okay,

16 so does everyone have the algorithm in front

17 of them?

18 　　　　　(Multiples yeses)

19 　　　　　MS. MUNTHALI: Okay. So we, let's

20 just start from the beginning. I think that

21 would be a lot easier. Are the submitted

22 specifications precise and ambiguous and

1 complete so that they can be consistently

2 implemented?

3   And if yes we would go to number

4 two, which is the second blue box on the

5 algorithm. And then here it's asking whether

6 the empirical reliabilities tested conducting

7 using the statistical test with the measure as

8 specified.

9   If we say no then we would go

10 towards the right and then it would ask us was

11 empirical validity testing of patient-level

12 data conducted? If we say no then we would

13 rate the measure at this point as

14 insufficient.

15   If we say yes we'd use the ratings

16 for a validity testing for our patient-level

17 data elements, and that would be on the next

18 page, which is Page 16.

19   So I don't know, for those who

20 voted insufficient, and, Emilio, are there any

21 specific questions that you had? Would you

22 like us to go further down the algorithm?

1   MR. CARILLO: No. Basically when

2   there is insufficient evidence, but there are

3   other rationale, other thinking for the

4   committee that might exempt the sufficient --

5   MS. MUNTHALI: Oh, so for like

6   evidence?

7   MR. CARILLO: Right.

8   MS. MUNTHALI: That's more

9   specific to the evidence sub-criterion, and so

10   for that, what Emilio is talking about, if you

11   go to the first page, which is importance to

12   measure and report and the sub-criterion of

13   evidence, if in the submission we did not find

14   sufficient evidence the committee can apply an

15   exception rule knowing that there's evidence

16   to support the measure.

17   It's not quite the same for

18   reliability and validity when we're assessing

19   it at the data element or measure score level.

20   And so I think that's what you were trying to

21   see if we can kind of apply an exception to

22   this --

1   MR. CARILLO: Yes. Right.

2   MS. MUNTHALI: -- knowing that you

3 may not feel that it meets all of these

4 criterion based on the guidelines.

5   MR. CARILLO: Correct.

6   MS. MUNTHALI: Okay. Are there

7 any other questions or concerns before we move

8 on. By the vote the measure has passed

9 reliability and now we'll be talking about

10 validity.

11   MS. ROBINSON-ECTOR: Okay. So

12 validity, including 2(b), specifications

13 consistent with evidence, 2(b)(2), testing,

14 appropriate method and scope with adequate

15 results and threats, 2(b)(3), exclusions,

16 2(b)(4) risk adjustment, stratification,

17 2(b)(5), meaningful differences, 2(b)(6),

18 comparability, data sources.

19   One is high, two is moderate,

20 three is low, four is insufficient, and voting

21 will begin now.

22   (Pause)

1   MS. ROBINSON-ECTOR: We're still

2   waiting for three votes. Okay, now two votes.

3   And one more vote. Okay, we're still waiting

4   for one vote. Okay, so all votes are in and

5   voting is now closed.

6   Okay. For high we had one vote,

7   for moderate we had 14 votes, for low we had

8   four votes, and for insufficient evidence

9   there were two votes.

10   MS. CHIANG: So I struggled with

11   this one because there were, it wasn't

12   entirely clear to me how we were supposed to

13   vote given that there was so many different

14   criteria.

15   So there's some that I agreed with

16   that had higher level and others that were

17   lower level, so it was very hard for me to

18   then put an aggregate response. I don't if

19   others --

20   MS. MUNTHALI: Yes, and that's

21   somewhat the difficulty of doing this exercise

22   is that we have this criterion, it's been

1 vetted, it's scientific, but then there is a

2 judgement call, of course.

3   That we're asking many of you

4 around the table with your different

5 perspectives to weigh in and so it's that

6 balance that we're trying to consider with the

7 voting on the evaluation criterion and sub-

8 criterion.

9   MR. VENKATESH: But I think what

10 you're eluding to is that it was hard to

11 evaluate 2(a), like make a composite score of

12 2(a), (b), (c), (d), and (e), at the same time

13 when you may have high for (a) and (b) or low

14 for (c) and something like that.

15   MS. CHIANG: And that's what I was

16 trying to say.

17   MS. MUNTHALI: And then coming up

18 with like a binary decision point, yes.

19   MS. SAMPSEL: Okay, if no other

20 questions we'll go ahead and move into

21 Criterion 3, which is feasibility and before

22 we go to vote were there any other questions

1   or comments, considerations, from the

2   committee? Okay, Kaitlynn, go ahead.

3   MS. ROBINSON-ECTOR: Okay.

4   Usability, meaningful, understandable, and

5   useful for public reporting and

6   accountability, 3(b), meaningful,

7   understandable, and useful for quality

8   improvement.

9   One is high, two is moderate,

10   three is low, and four is insufficient

11   information, and voting will begin now.

12   MR. SPANGLER: Wait. I have a

13   question real quick.

14   MS. ROBINSON-ECTOR: Oh, you had a

15   question.

16   MR. SPANGLER: I thought three was

17   feasibility and four was usability?

18   MS. ROBINSON-ECTOR: You are

19   correct, and actually it's use and usability

20   for four. We've just noted that these are the

21   old criterion slides that were implemented a

22   couple of years ago and so we probably should

1   take a break to correct it, so we'll do so.

2   If we can take --

3   MS. SAMPSEL: Okay.

4   MS. ROBINSON-ECTOR: If we could

5   ask the chairs for about five minutes?

6   MS. SAMPSEL: Okay. Everybody,

7   let's take a break.

8   (Whereupon, the foregoing matter

9   went off the record at 11:04 a.m. and went

10   back on the record at 11:13 a.m.)

11   MS. SAMPSEL: So we think things

12   have been, or we know things have been

13   readjusted and now the votes will now align

14   with the review forms that we all worked on.

15   And so we'll pick up with

16   feasibility here and just wanted to start

17   again with the discussion about feasibility

18   and since this was one of the measures that I

19   reviewed, you know, I think in the general

20   terms of is the measure feasible for reporting

21   by the intended audience of reporting, which

22   would be health plans and integrated delivery

1   systems, this measure does seem to meet all

2   feasibility criteria.

3   It seems that some of the

4   discussions that happened on the workgroup

5   were more about can you capture the codes and

6   could a plan capture a code because they are

7   dependant on claims and, especially with the

8   new codes on the risk assessment.

9   So with that I will go ahead and

10   open up for any other additional questions or

11   comments that folks had about feasibility of

12   this measure before we go to vote on

13   feasibility.

14   (Pause)

15   MS. SAMPSEL: Okay, go ahead,

16   Kaitlynn.

17   MS. ROBINSON-ECTOR: Okay. For

18   feasibility 3(a), data generated during care,

19   3(b), electronic sources, and 3(c), data

20   collection can be implemented, eMeasure,

21   feasibility, assessment of data elements and

22   logic.

1   One is high, two is moderate,

2   three is low, and four is insufficient, and

3   voting begins now.

4   (Pause)

5   MS. ROBINSON-ECTOR: Okay, we're

6   still waiting on two votes and there's about

7   30 seconds left. Okay, we're still waiting on

8   one vote and there's 20 seconds left. Still

9   waiting on one more vote. Okay, we have all

10   of our votes and voting closes now.

11   Okay, for high there were 14

12   votes, for moderate there were six votes, for

13   low there was one vote.

14   MS. SAMPSEL: Jane?

15   MS. CHIANG: Is abstaining from a

16   vote an option?

17   MS. SAMPSEL: No.

18   MS. MUNTHALI: So the only reason

19   that we would, you know, say that someone

20   could abstain is if they were involved in

21   measure development.

22   We really value everyone's

1   perspective, so perhaps you can, if you'd like

2   to say the reasons why you're uncomfortable

3   with the criteria and how this measure meets

4   it or does not we can note it for our public

5   record and the report.

6   MR. FRANCE: Just a process

7   comment. I find it a little distracting when

8   I'm trying to decide to hear "still two votes,

9   still one vote, 20 seconds."

10   I'd prefer if it were quiet when

11   I'm voting personally and then at the moment

12   that everybody's done we're done rather than

13   the commentary about how many votes are left.

14   MS. MUNTHALI: Okay, thank you.

15   That's noted, Kaitlynn.

16   MS. SAMPSEL: Okay. We'll now

17   move onto usability and use of this measure,

18   and prior to going to vote are there any other

19   comments or questions?

20   You know, during the workgroup

21   discussion and comments received prior to the

22   meeting there really weren't any comments on

1   this part of it, but this is the criterion

2   regarding extent to which potential audiences

3   are using or could use performance results for

4   both accountability and performance

5   improvement.

6   And I know the DQA talked about

7   that a little bit to address some other

8   questions. So any other questions or comments

9   regarding usability? Go ahead, Kaitlynn.

10   Oops, sorry. David?

11   MR. KROL: So this one for 4(b)

12   for the progress demonstrated as far as, I

13   don't know, this is the one where there may be

14   a combination of some, the question that came

15   up earlier about (a), (b), (c) trying to find

16   out how you weigh each of those to get to your

17   final number.

18   Because this is so new in Texas

19   and maybe Connecticut, I'm not sure that

20   they've gotten to the point where they're

21   showing if it's having sufficient evidence to

22   see if progress has been demonstrated on

1   improvement yet.

2   So, for instance, in my, I'm not

3   sure how I'll factor in an insufficient for

4   4(b) with other numbers for the others. I

5   don't want to give a, you know, does one

6   insufficient of those three make the whole

7   thing insufficient? I have some challenge on

8   that one, 4.

9   MS. KHAN: So I would note that as

10   part of 4(b) if it's a new measure we're not

11   really looking for if there's been progress

12   demonstrated, but if the rationale exists.

13   So there are some nuances for

14   maintenance measures versus the new measures

15   and we've tried to note them in the voting

16   slides, but essentially we just want to make

17   sure that it's, there's a credible rationale

18   for demonstrating improvement as part of 4(b),

19   yes.

20   MS. SAMPSEL: Okay, Kaitlynn.

21   MS. ROBINSON-ECTOR: Okay. So for

22   usability and use, 4(a), accountability,

1   transparency, use and accountability within

2   three years, public reporting within six

3   years, or if new, credible plan, and 4(b),

4   improvement, progress demonstrated, if new

5   credible rationale, and 4(c), benefits

6   outweigh evidence of unintended negative

7   consequences to patients and/or populations.

8   One is high, two is moderate,

9   three is low, four is insufficient, and voting

10 begins now.

11   (Pause)

12   MS. ROBINSON-ECTOR: Okay. We now

13 have 21 votes and voting will end. For high

14 there were nine votes, for moderate there were

15 11 votes, for low there was zero votes, for

16 insufficient information there was one vote.

17   MR. CARILLO: Just a question.

18 For me, I don't if anybody else, it's kind of

19 hard to see the small print on that screen.

20 I wonder whether they can be substituted for

21 this display here?

22   MS. KHAN: Unfortunately --

```
 1                    MR. CARILLO:  For displaying --
 2      You can't.
 3                    MS. KHAN:  -- the software that we
 4      use for voting can only be displayed on that
 5      laptop.
 6                    MR. CARILLO:  I see.
 7                    MS. KHAN:  And so that's why, but
 8      --
 9                    MR. CARILLO:  All right, I'll move
10      up if I have to.
11                    MS. KHAN:  Okay.
12                    MR. CARILLO:  Thank you.
13                    MS. SAMPSEL:  So we can move onto
14      the overall vote for endorsement.
15                    MS. ROBINSON-ECTOR:  Okay.  So
16      does the measure meet NQF criteria for
17      endorsement?  Note, this may not yet be a
18      recommendation for endorsement.  Final
19      recommendation for endorsement may depend on
20      assessment of any related and competing
21      measures.
22                    One is yes, two is no.  Voting
```

1   begins now.

2   (Pause)

3   MS. ROBINSON-ECTOR: Okay, we now

4   have all of our votes and voting will close.

5   So for the recommendation of the measure there

6   were 18 votes for yes and three votes for no.

7   So the measure will pass recommendation.

8   MS. MUNTHALI: And just for our

9   transcript and our recording, the measures

10   2508, Prevention of Dental Sealants for 6 to

11   9 Year Old Children at Elevated Caries Risk.

12   MS. SAMPSEL: Okay. So as, you

13   know, both Helen and Elisa and I announced

14   earlier this morning, the first measure's

15   always the hardest one and, you know, we kind

16   of go through some quirks, we learn about the

17   process, and we learn about working together

18   for the first one.

19   And we'll probably continue to do

20   that through the rest of the measures, but

21   we'll go ahead and move on to 2509 and before

22   doing so I want to do a couple things.

1   One, we're going to switch the

2   process a little bit and have the discussants

3   go through each criterion one at a time so we

4   don't forget anything from, you know, if we go

5   through it all together then we're at jeopardy

6   of forgetting some of those conversations by

7   the time that we vote.

8   So we'll go through Criterion 1,

9   we'll go through and vote, go through

10   Criterion 2, vote, go through Criterion 3 and

11   vote.

12   You know, appreciate the concern

13   about announcing of the votes, but what we'll

14   ask Kaitlynn to do is at 45 seconds in if she

15   still doesn't have all 21 just notify folks

16   because we do need to get all of the votes in

17   within that 60 seconds or we'll have to all

18   re-vote and we want to avoid that as well.

19   Anything other process wise we

20   want to --

21   MS. MUNTHALI: No, that's it.

22   MS. SAMPSEL: Okay, so with that,

1   oh, John?

2   MR. AUERBACH: You know, I hope

3   this isn't inappropriate, but for those of us

4   who are new I wonder if we could take five

5   minutes just to have a discussion about

6   process or just ask questions, or about the

7   appropriateness of, you know, participating in

8   particular ways?

9   MS. SAMPSEL: Sure.

10   MR. AUERBACH: There's a cluster

11   of us that are new down this end.

12   MS. SAMPSEL: Okay.

13   MR. AUERBACH: And I just think it

14   would be helpful to know certain things that

15   I think maybe the more experienced folks know.

16   MS. SAMPSEL: Okay, ask away.

17   MR. AUERBACH: Well I'll start,

18   but I hope I'm not the only one. It would be

19   helpful for me to understand the expectations

20   with regard to committee members and

21   presenting as we go through.

22   I didn't come in with any

1   particular expectations about formalized

2   presenting and so just the, a little bit of

3   just discussing the balance between committee

4   members versus the developers of the criteria,

5   or proposals, would be helpful for example.

6   MS. SAMPSEL: Okay. And I'll let

7   NQF staff respond to this as well regarding

8   their expectations, but I think this is an

9   area that past committee members can help with

10   as well.

11   And, you know, my perspective is,

12   you know, if you have a question ask it. You

13   know, if it's helping or if there's something

14   you want answered in order to understand how

15   you would want to vote.

16   But when we're presenting the

17   measures, at least my perspective is to do the

18   highlights and stop at those things either in

19   the workgroup that we brought up or as I

20   myself in understanding the measures would

21   want some kind of explanation for in order to

22   give a response to and that's where I think

1   it's the improved process of having the

2   developers here in the room as well.

3   So, you know, I don't think it's,

4   you know, it's not necessary for you to go

5   into extraordinary detail, but to be able to

6   hit those things that really could impact a

7   vote, you know, with any of the criterion.

8   MS. MUNTHALI: And just to add, we

9   have just put up on the screen a script for

10   introducing measures for the discussion and we

11   are going to copy them for the entire

12   committee and this is something we sent out

13   with materials in preparation for today's

14   meeting, and really just to be, as Sarah said,

15   just to give highlights of the criterion in

16   order.

17   So for importance we'd give, just

18   as we did, for evidence, opportunity for

19   improvement, impact, and then we'd move on to,

20   we'd for each one of those, after each one,

21   we'd have a committee discussion and committee

22   vote on whatever sub-criterion that is, and so

1 we've indicated so on the script.

2   And then we'd go down to the next

3 criterion of scientific acceptability to

4 measure and report, and then we would talk

5 about reliability, have a committee

6 discussion, vote on that, go down to validity,

7 have a committee discussion, vote on that, and

8 then we'd also go to feasibility, vote on that

9 criterion, and then we would go to use and

10 usability and have a discussion and vote on

11 that.

12   So just very high level, a

13 synopsis of what the workgroup discussed, any

14 of the issues that came up during the

15 workgroup we'd like to discuss as well, and

16 this is the opportunity to really ask

17 developers who are here.

18   We appreciate your attendance and

19 your explanation in advance of some of the

20 issues that came up in the workgroup, but this

21 is your opportunity to ask questions of them

22 as well.

1   MS. KHAN: And I just want to add,

2   we are getting copies for you, but if you, in

3   the meantime, it is posted on the SharePoint

4   site, so you can, if any of you have your

5   laptops you can pull it up and just kind of

6   follow the way the outline works, and

7   hopefully that'll streamline the discussion

8   quite a bit.

9   MS. SAMPSEL: Jane?

10   MS. CHIANG: So just to reiterate

11   what John said, I think what we're asking for

12   is in regard to the voting process there, we

13   can have a robust discussion about the various

14   measures, et cetera, but when there are times

15   when you have a series of questions and you

16   are asked, kind of like what David was saying,

17   you have to weigh these different factors, it

18   makes it very difficult.

19   Because these are important

20   measures it makes it very difficult for me to

21   rank order them quickly and then to make a

22   vote. And I guess I'm a little cautious

1   because we can all say that yes, for (a), (b),

2   and (c) it meets the high, but then there's a

3   couple that are concerning, do we just give

4   that whole thing an insufficient measure or a

5   low, insufficient evidence or low?

6   So that's kind of what I'm

7   referring to, and the other thing that I'd

8   like to hear a little bit more that if there

9   is, if I prefer to abstain from a vote of if

10   there's disagreement where is, at what point

11   do we talk about that?

12   So I would like to know what's the

13   process for that?

14   MS. MUNTHALI: Yes, those are very

15   good questions and that's why we've come up

16   with the algorithms as a guidance to

17   evaluating the measures, but also we would

18   like you to talk about those issues.

19   We realize that consensus doesn't

20   mean agreement by the entire committee and so

21   we, even if you have some concerns we want to

22   represent the opinions, all of the opinions of

1   the Committee in our final report. That will

2   be the recommendation on the different

3   measures.

4   And so, but I'd like to hear what

5   other Committee think and I think, Arjun, you

6   have a question.

7   MR. VENKATESH: Yes. I think it's

8   related to that in a sense that one of the

9   criticisms of the previous consensus

10   development process has been that it was not

11   consistent within committees.

12   And so that a measure, you know,

13   may not be found to have validity, but a very

14   similar measure could come to that committee

15   later on and then be viewed as such.

16   And I think one of the things

17   we're struggling with as a new group coming

18   here is getting some general sense of what

19   that shared consistency and reliability looks

20   like within the way we vote, you know.

21   So when I say moderate am I

22   thinking the same thing as somebody else when

1   they say moderate? Would it be too much to

2   ask if we said that in the kind of, either

3   during the lead discussant portion of

4   presenting kind of the workgroup's thoughts

5   about a measure or when people speak about

6   this measure that to some degree you kind of

7   say, you know, I think, I feel like it's a

8   moderate because of this or whatever the

9   concern is?

10   And I think that that would then

11 help people understand how to, kind of in a

12 shared way, interpret things that they see?

13   MS. MUNTHALI: Yes, absolutely.

14 And this, I would just call the committee's

15 attention again to the algorithms because the

16 algorithms were developed for that reason, to

17 bring about consistency.

18   So we're applying these and using

19 them in all of our consensus development

20 projects. So it's giving you guidance on

21 where you would rate that measure based on the

22 criterion and sub-criterion.

1   And I think definitely, this is

2   the day that you are voting on those measures

3   and so I think it's really within your purview

4   to say this is the reason why, but we want to

5   have some sort of rationale associated with it

6   that is based on something that can be applied

7   for another measure that may come up during

8   the next cycle of Health and Well Being

9   measures.

10   So that's really the reason why we

11   put together the guidance because we knew

12   people were struggling. It's really, really

13   hard to kind of come up with standardization

14   when you're using, you know, this scientific,

15   you know, measure evaluation guidance, but

16   also subjectivity depending on what your

17   perspective is.

18   MS. NISHIMI: And I really do want

19   to emphasize folks having the algorithm in

20   front of them as they think about the high,

21   low, moderate.

22   They are really intended to remove

1 the subjectivity and sort of group think,

2 loudest voice, saying it's low type of thing.

3 I mean it's really important for you to sort

4 of internalize the messaging that's carried

5 within this document.

6 It's developed specifically to

7 even out steering committee performance.

8 MS. MUNTHALI: Are there other

9 questions about the process?

10 MS. KHAN: I will add that if we

11 do have a vote where we have a significant

12 number or even like one or two people that

13 were in disagreement we are more than welcome

14 to capture your comments as part of our

15 report.

16 We actually really do look for

17 that feedback as to why someone didn't agree

18 with why a measure didn't meet the criteria,

19 so feel free to share your thoughts whenever.

20 MS. SAMPSEL: Okay.

21 MS. KHAN: Oh, I think Patty --

22 MS. SAMPSEL: Oh, I'm sorry, go

1 ahead.

2 MS. MCKANE: There it goes. When

3 do we have that opportunity to share our

4 thoughts that may be, some of mine I know were

5 a little bit divergent and it's based on my

6 background and my perspective of this, and

7 also my interpretation of your algorithm.

8 So is that going to be after the

9 close of the meeting or, do I have to remember

10 that or do we speak out at other times? And

11 I'm also, you know, one of the people that

12 I'm, this is, and I also see like a lot of

13 gray areas sometimes where it's just not

14 clear, you know.

15 When I'm doing this, you know,

16 there's tons of different interpretations and,

17 you know, I know you're trying to bring

18 consistency and to try to ensure that

19 everybody has a voice and that's great, but in

20 some ways it becomes difficult for me to

21 translate all that into a vote.

22 Because sometimes I see things as

1   being, I'll see it has strengths here, it has

2   weaknesses here, and is that weakness, does

3   that override, and to me in some places that's

4   so important, it's not being addressed, but

5   when I have to follow that algorithm then that

6   goes away.

7   MS. KHAN: So what I would say is

8   that as we move towards using kind of this

9   script as the way we're going to have

10 discussion is that if you have an issue with

11 one of the criteria, say evidence for example,

12 I would bring it up during that discussion, we

13 would take the vote, if you wanted to make a

14 comment post-vote we would more, we'll capture

15 that in the transcript and we'll have that in

16 the report as well.

17   So it's really just whenever the

18 Committee has the discussion. We don't want

19 to be too prescriptive either because we want

20 the conversation to kind of flow naturally,

21 but I would say I think going to this kind of

22 script model will be helpful for everyone to

1   be able to voice their opinion in an organized

2   way.

3   MS. SAMPSEL: Okay. Any other

4   questions about process? Then we will go

5   ahead and move to Measure 2509 and prior to

6   the discussion leaders starting I wanted to

7   find out, Krishna, Dr. Crall, any brief

8   comments about this measure?

9   MS. ARAVAMUDHAN: I'll keep it

10   really brief. This is very, very similar to

11   the previous measures it simply goes to the

12   next age cohort when the next molar comes into

13   the mouth and, again, the rationale,

14   everything is the same.

15   So I don't want to belabor it, I

16   just want to point out one thing that during

17   the break we had a conversation about the

18   measure testing and validity where we have

19   very high kappa statistics to demonstrate that

20   there is a lot of concordance with the claims

21   data as well as the chart reviews.

22   We can definitely have Dr. Herndon

1   present a little bit more if you have any

2   questions regarding that, but I did want to

3   call that out to your attention.

4   MS. SAMPSEL: Robert?

5   MR. VALDEZ: I'm sorry, I didn't

6   get my tag up fast enough. This actually

7   isn't about the measures, it's a follow up to

8   this last discussion.

9   The one are that we don't as a

10   group have a chance to really talk is whether

11   or not we in fact are endorsing or not

12   endorsing after we've taken all of these

13   criterion into account, because one of the

14   things that we're asked to think about is,

15   well how does this measure fit with other

16   measures that are likely to come?

17   The developers in fact talked to

18   us in this last measure as an example that

19   they had a measure that was dental, they had

20   a measure that was oral, and they had a

21   measure that was dental or oral to capture the

22   fact that the children in fact had received

1   the arrangements.

2   But we never really had an

3   opportunity to talk about that before we were

4   asked to actually vote on that kind of issue,

5   because it's not really part, it wasn't really

6   part of the discussion piece.

7   So it would helpful to at least

8   have some discussion about the overall

9   assessment of endorsements as a group because

10   it requires us to in fact create all these

11   other things plus the sense of the family of

12   measures that potentially could be brought

13   forth.

14   MS. MUNTHALI: Absolutely, and I

15   think that would be another discussion point

16   for tomorrow when we talk about the portfolio

17   in more detail when we're talking about GAPs

18   and harmonization.

19   I think one of the recommendations

20   you can make is, you know, to see a measure

21   like DQA said that they are in the process of

22   developing. I think that is within the

1   committee's purview.

2   MS. SAMPSEL: Okay, so with that

3   Measure 2509, Margaret, Ron, which of you were

4   going to lead?

5   (Off microphone discussion)

6   MS. SAMPSEL: Oh, okay. So Ron by

7   default.

8   MR. INGE: By default just like on

9   our conference call this measure is very

10   similar to the one we just discussed. All of

11   the evidence, all of the parameters are the

12   same.

13   We're simply looking at a

14   different tooth in the mouth based upon the

15   eruption pattern. I'm not sure if you want me

16   to go through each step again because we'll

17   repeat what we spoke about the first time, so

18   I'm asking that question.

19   MS. SAMPSEL: Yes. I mean I don't

20   think it's necessary to go through the same

21   talking points.

22   MR. INGE: Okay.

1   MS. SAMPSEL: But what we'll want

2   to do is go ahead and start with Criterion 1

3   so then we can ask to go to a vote and to the

4   same option, open it up to see if anybody has

5   any different discussion on Criterion 1 to

6   start with.

7   MR. INGE: Okay.

8   MS. SAMPSEL: And then as we go

9   through.

10   MR. INGE: Okay. And we lost

11   Kaitlynn.

12   FEMALE PARTICIPANT: She's

13   standing out --

14   MS. SAMPSEL: Oh, there she is.

15   MR. INGE: Okay, so Criterion 1 is

16   the evidence. It's stated similar to the

17   first in regards to the prevalence of decay

18   and also the studies that support the

19   placement of sealants for the reduction of

20   decay.

21   I think that's really the only

22   real comment about the evidence from that

1   standpoint. Performance in the measure,

2   again, something that can be captured through

3   CDT codes that are very commonly used to

4   identify risk.

5   It's also an opportunity with the

6   new risk codes as well as the use of history,

7   that is the restoration that had been placed

8   previously, will also help to define risk of

9   a patient population.

10   MS. SAMPSEL: Okay. From the

11 committee, for Criterion Number 1 and

12 importance to measure and report were there

13 any other additional questions or comments

14 that anybody wanted out on the table for

15 discussion before vote?

16   Okay, Kaitlynn. Oh, I'm sorry,

17 Jane?

18   MS. CHIANG: So is the evidence

19 better or is it the same?

20   MR. INGE: It's basically the

21 same.

22   MS. CHIANG: Okay, thank you.

1   MS. ROBINSON-ECTOR: Okay. For

2   1(a), evidence outcome, health outcome with

3   rationale yes, or quantity and quality,

4   consistency of body of evidence, moderate or

5   high.

6   MS. KHAN: It's actually 1(a),

7   evidence for a processed measure.

8   MS. ROBINSON-ECTOR: Oh, gosh,

9   okay. There we go. Okay, so 1(a), evidence

10   process, so 1(a), evidence for quantity or

11   quality, consistency from SR was submitted,

12   box 5(a) high, 5(b) moderate, 5(c) low.

13   If QQC not submitted and graded

14   guideline recommendation box 6, yes moderate,

15   no low. If empirical evidence without SR box

16   9, yes moderate, no, no, low, sorry.

17   If expert opinion, box 12, yes,

18   insufficient without exception, no,

19   insufficient. One is high, only eligible if

20   QQC submitted, two is moderate, three is low,

21   four is insufficient evidence, five is

22   insufficient evidence with exception.

1   MS. KHAN: Right. So we're

2   looking at algorithm 1, it's the first page,

3   guidance for evaluating the clinical evidence,

4   and the box numbers are the ones that are

5   called out into the voting slide.

6   (Pause)

7   MS. SAMPSEL: Okay, are folks

8   ready to vote?

9   MS. ROBINSON-ECTOR: Okay. The

10   vote is now open.

11   (Pause)

12   MS. ROBINSON-ECTOR: Okay, there

13   are two more votes out.

14   (Pause)

15   MS. ROBINSON-ECTOR: Okay. All

16   votes are in. For 1(a), evidence, seven voted

17   for high, there were 14 votes for moderate,

18   zero votes for low, zero votes for

19   insufficient evidence, and zero votes for

20   insufficient evidence with exception.

21   MS. SAMPSEL: Thank you. So, oh,

22   sorry, we're on 1(b).

1   MS. ROBINSON-ECTOR: Okay, so

2   1(b), performance gap, data demonstrated

3   considerable variation or overall less than

4   optimal performance across providers and/or

5   population groups, disparities and care.

6   One is high, two is moderate,

7   three is low, and four is insufficient.

8   Voting begins now.

9   (Pause)

10   MS. ROBINSON-ECTOR: All votes are

11   in and voting will end now. For 1(b) there

12   were 13 votes for high, eight votes for

13   moderate, zero votes for low, and zero votes

14   for insufficient.

15   MS. SAMPSEL: And, Ron, before we

16   move to vote on this, for 1(c) were there any

17   notes, comments, regarding priority on this

18   measure?

19   MR. INGE: None that I have. Let

20   me just look.

21   MR. MCINERNEY: On Page 64 it says

22   that the high priority yes because it was

1   specifically requested by CMS and it was

2   recommended as moderate.

3   MS. ROBINSON-ECTOR: 1(c), high

4   priority, addresses a specific National health

5   goal, priority, or data demonstrated at a high

6   impact aspect of healthcare, numbers affected,

7   resource, use, severity, consequences.

8   One is high, two is moderate,

9   three is low, and four is insufficient.

10   Voting begins now.

11   (Pause)

12   MS. ROBINSON-ECTOR: We now have

13   all 21 votes and voting will close. For 1(c),

14   high priority, there were 16 votes for high,

15   four votes for moderate, one vote for low, and

16   zero votes for insufficient.

17   MS. SAMPSEL: Okay, so we'll move

18   into the next area of scientific acceptability

19   and, Ron, I'll ask you if you'll look at the

20   discussant guide and just if you could

21   highlight those areas in that guide.

22   What we want to make sure, and

1 again this is just going back to process, is

2 making sure that we do for each measure,

3 consider them individually, that even though

4 these all came together, they are individual

5 measures.

6   And, you know, we're not going to

7 ask anybody to repeat the conversation that we

8 just had on the other measure, at the same

9 time we do want to get on record that we had

10 this conversation, that we are all considering

11 the correct measure, which was 2509, and let's

12 just bring up the specific details about the

13 measure regarding numerator, denominator, and

14 scientific acceptability properties.

15   MR. INGE: So in regards to the

16 liability and validity the methodology --

17   (Off microphone discussion)

18   MR. INGE: The methodology that

19 was put forth is very specific. The tooth

20 number, the use of identifying codes, very

21 specific, was repeatable in two different

22 populations, so I felt that it had a high

1   reliability as well as validity within the

2   measure.

3   MS. SAMPSEL: Krishna, go ahead.

4   MS. ARAVAMUDHAN: Sure. I do want

5   to point out here once again that this is

6   where, you know, we failed to mention last

7   time that we do have very high kappa scores.

8   We did conduct testing to seek, in

9   accordance with reviews, to whether it's the

10 claims data, so very high kappa scores in

11 terms of inter-rater liability.

12   We also had data for different

13 calendar years as well as data between

14 different plans, so all that information for

15 this measure is available within your measure

16 tasking form.

17   MS. SAMPSEL: And other questions,

18 comments, concerns, about scientific

19 acceptability? Go ahead, Ron.

20   MR. BIALEK: I've been grappling

21 with the criteria that the, the document that

22 has the population health guidance on that and

1   it, in 2(b)(5) it talks about will the

2   measure, you know, allow for determining a

3   variation across populations and improving

4   health.

5   Or there is evidence of overall

6   less than optimal performance of significant

7   variation across populations and so, I mean

8   the way I'm interpreting that is that if there

9   is noted disparities as has been suggested by

10   the measure developers then those disparities

11   should be able to be teased out in the

12   measure. Is that what this says or not?

13   MS. MUNTHALI: Adeela, can you

14   actually pull up the guidance so we can walk

15   the committee through it? It's the Population

16   Health Measure Evaluation Guidance.

17   (Off microphone discussion)

18   MS. MUNTHALI: It's the one

19   before, yes.

20   Okay, so what we did just for

21   background, earlier when I mentioned the first

22   project on population health measures I talked

1   about the foundation of work that the

2   committee did and part of that was really

3   looking at the NQF measure evaluation criteria

4   to see if the criteria are applicable to

5   population level measures.

6   And by and large the committee

7   felt that they were, but with some nuances or

8   guidance around nomenclature on making sure

9   that the references that we had to the

10   healthcare system were applicable and more

11   widely applied to population health settings.

12   And so, Ron, you were talking

13   about 2(b)(5)?

14   MR. INGE: Yes.

15   MS. MUNTHALI: Okay. And so what

16   you have on the left side is our current

17   measure evaluation guidance for non-population

18   based measures and what you have on the right

19   side is the guidance that the committee came

20   up with.

21   What the added is the text in red.

22   And so Ron is talking about the variation

1   across populations and improving health and

2   wondering whether or not this, would this sort

3   of difference in population should be

4   reflected in the measure as disparities.

5   And so this is one thing you might

6   factor in as you're rating the, I think it's

7   validity, is it? Am I correct? Yes.

8   MALE PARTICIPANT: Yes.

9   MS. MUNTHALI: So, Krishna, did

10   you want to respond to -- Okay, they haven't

11   done so.

12   MS. ARAVAMUDHAN: We do have data

13   there to show you disparities by age, by

14   different things, so, yes, there are

15   disparities in population and yes, we hope

16   that this measure will trigger improvement in

17   those areas.

18   MS. MUNTHALI: And we just wanted

19   to let everyone know this is available on your

20   SharePoint site. So you can refer to it as

21   you're evaluating these measures.

22   MS. ROBINSON-ECTOR: Okay. So

1   2(a), reliability, including 2(a)(1), precise

2   specifications, 2(a)(2), testing, appropriate

3   method, and scope with adequate results.

4   One is high, two is moderate,

5   three is low, and four is insufficient, and

6   voting begins now.

7   (Pause)

8   MS. ROBINSON-ECTOR: Okay, we're

9   still waiting for two votes.

10   (Pause)

11   MS. ROBINSON-ECTOR: One vote.

12   (Pause)

13   MS. ROBINSON-ECTOR: So we missed

14   one vote, so we have to go back and enter it

15   again. Okay, voting begins now.

16   (Pause)

17   MS. ROBINSON-ECTOR: We have all

18   of the votes and voting is now closed. Okay,

19   so for high there were five votes, there were

20   15 votes for moderate, zero votes for low, and

21   one vote for insufficient.

22   Okay. So for validity, including

1   2(b)(1), specifications consistent with

2   evidence, 2(b)(2), testing, appropriate method

3   and scope with adequate results and threats

4   addressed, 2(b)(3), exclusions, 2(b)(4), risk

5   adjustment/stratification, 2(b)(5), meaningful

6   differences, 2(b)(6), comparability, multiple

7   specifications, 2(b)(7), missing data,

8   eMeasures, compositives, PROs, PMs.

9   One is high, two is moderate,

10   three is low, and four is insufficient.

11   Voting begins now.

12   (Pause)

13   MS. ROBINSON-ECTOR: We now have

14   all of our votes and voting will close. There

15   are four votes for high, 16 votes for

16   moderate, one vote for low, and zero votes for

17   insufficient.

18   MS. SAMPSEL: So before we move

19   onto the next major criterion I just wanted to

20   pause for a minute and, you know, to reflect

21   and see if there were any overall concerns

22   that anybody wanted to air about the

1   scientific acceptability of this measure?

2   Okay. So then moving into

3   feasibility and, Ron, again, this goes back to

4   the measure worksheet and any comments that

5   should be brought up would be about data

6   sources, if you could comment data sources,

7   and if any feasibility concerns had been

8   brought up regarding this measure before we

9   vote.

10   MR. INGE: The only concern would

11   be that the data source is claims data and

12   that claims data does not account for those

13   individuals who have not entered the system,

14   that would be the only challenge around the

15   data source.

16   MS. SAMPSEL: Okay. Any other

17   questions or comments about feasibility?

18   Okay, Kaitlynn.

19   MS. MCKANE: It's just that it's,

20   the claims are within the Medicaid claims,

21   right?

22   MR. INGE: Medicaid or commercial.

1   MS. MCKANE: Or commercial?

2   MS. SAMPSEL: So these are

3   Medicaid and commercial, Krishna?

4   MS. ARAVAMUDHAN: I'm sorry, yes.

5   The measure will apply to both Medicaid and

6   commercial sectors. So as was pointed out

7   before, anyone who has not had a touch point

8   with a system, who's had no claims, but is

9   sort of enrolled just not seeking care, will

10   not be reflected in this measure, but it goes

11   back to the point that we made that there's no

12   one magic measure, there are other measures

13   like the utilization which will pickup

14   enrollees who are not using the system.

15   MS. SAMPSEL: David?

16   MR. KROL: Yes. That just, it

17   just struck me that that brings up the

18   question if the individual has come for the

19   first time to see the dentist and how does the

20   risk status, if the risk status at that first

21   visit isn't determined by the three CDT codes

22   then presumably they wouldn't have any risk

1 status at all because the basis of risk

2 status, the alternative basis of risk status

3 is based on previous interaction with the

4 system by having had a number of CDT codes

5 before.

6   So what happens to the individual

7 that's never had an interaction with the

8 system and this is their first time being

9 measured? The first time, do you follow what

10 I'm saying?

11   MS. ARAVAMUDHAN: Okay, yes. We

12 tried to do things like add some more risk

13 logic to say okay, if they have never been

14 with the system automatically bump them up to

15 high risk and capture that.

16   But there were validity issues, we

17 went through a whole face validity process

18 with that and there was simply not agreement

19 that that would be a good thing to do with the

20 measure, especially being a performance

21 measure.

22   So what passed the face validity

1   is use this measure to identify the core group

2   that can be identified using claims. Now

3   let's say we had great performance with that

4   core group, we'd say okay, it's time to move

5   on, let's figure out where the kids were

6   losing.

7   Now because we're seeing a

8   performance gap even with the kids that can

9   identified using claims data, this is a

10   measure to push towards that. So eventually

11   by then we are hoping that the CDT codes will

12   kick in.

13   The user services, the oral

14   evaluation measures will help improve that

15   access concern and then move the system

16   forward. So this is meant just for that core

17   group that can be identified as high risk.

18   MR. KROL: Okay, so they wouldn't

19   be included in the denominator, those folks

20   that came for the first time --

21   MS. ARAVAMUDHAN: Now denominators

22   simply are enrollees, it doesn't even require

1 a use of the health system.

2   MR. KROL: Well actually it's not,

3 it's enrollees who are at elevated risk.

4   MS. ARAVAMUDHAN: They are at --

5   MR. KROL: So, and you just said,

6 if I heard you correctly, it's individuals who

7 have not had a visit before and don't have one

8 of the three CDT codes that define risk, they

9 will not, you won't be able to assess risk?

10   MS. ARAVAMUDHAN: Correct. So

11 they have to be in the system this year or the

12 past three years. So then you could identify

13 them as the core group.

14   So you're right that we will lose

15 some people, but, again, the point was if we

16 did great with that core group that absolutely

17 needed this prevention we'd be looking at the

18 next set, but we just aren't doing so well

19 even with that core group.

20   MR. CRALL: And I was just going

21 to add, this is an older group and it is the

22 group that historically we know is most likely

1   to use services within the pediatric

2   population, sorry.

3   MS. SAMPSEL: Any other questions

4   or concerns? Kaitlynn.

5   MS. ROBINSON-ECTOR: For

6   feasibility, 3(a), data generated during care,

7   3(b), electronic sources, and 3(c), data

8   collection can be implemented, eMeasure,

9   feasibility, assessment of data, elements, and

10   logic.

11   One is high, two is moderate,

12   three is low, four is insufficient. Voting

13   begins now.

14   (Pause)

15   MS. ROBINSON-ECTOR: Thank you.

16   We now have all of our votes and voting will

17   close. For feasibility there were 13 votes

18   for high, eight votes for moderate, zero votes

19   for low, and zero votes for insufficient.

20   MS. SAMPSEL: Okay, and we'll move

21   into usability and use and I think, as has

22   been previously stated, this measure is in

1   current use and has been required some States.

2   Ron, were there any other comments

3   gathered on usability and use?

4   MR. INGE: No, just that it's in

5   limited use at this time.

6   MS. SAMPSEL: Krishna, anything?

7   MS. ARAVAMUDHAN: Nothing. It's a

8   new measure and this is very parallel to the

9   previous measure.

10   MS. SAMPSEL: And, Kaitlynn.

11   MS. ROBINSON-ECTOR: Usability and

12   use, 4(a), accountability, transparency, used

13   in accountability within three years, public

14   reporting within six years, or if new,

15   credible plan, and 4(b), improvement, progress

16   demonstrated, if new, credible rationale, and

17   4(c), benefits outweigh evidence of unintended

18   negative consequences to patients/populations.

19   One is high, two is moderate,

20   three is low, and four is insufficient, and

21   voting begins now.

22   (Pause)

1   MS. ROBINSON-ECTOR: We need one

2   more vote. All of the votes are in and voting

3   will now close. For usability and use there

4   were ten votes for high, nine votes for

5   moderate, one vote for low, and one vote for

6   insufficient information.

7   MS. SAMPSEL: Okay. So before we

8   go to the overall suitability for endorsement

9   we'll go ahead, again, and pause for any

10   questions or comments or concerns because this

11   is the overall vote.

12   MS. ASOMUGHA: So I don't know if

13   it's a concern or an anxiety, but I know we're

14   supposed to be looking at these measures

15   individually, but you could almost assume that

16   the previous one is like a pair to it,

17   correct, or no? I mean --

18   MS. ARAVAMUDHAN: I don't quite

19   understand the concept of a paired measure as

20   NQF uses that term.

21   MS. ASOMUGHA: Oh.

22   MS. ARAVAMUDHAN: I see paired

1   measures more as in order to interpret the

2   measure you have to have both these scores, if

3   I'm thinking right, that's not the case with

4   this. It can stand independently.

5   MS. ASOMUGHA: Sorry, I wasn't

6   using it in the way that NQF is using it.

7   (Laughter)

8   MS. ARAVAMUDHAN: So with that I,

9   both the measures can stand independently. I

10   think from a best practice standpoint the

11   advice we would go to give to programs and

12   plans adopting these measures is use both

13   together because you want to make sure that

14   the child is being followed.

15   MS. ASOMUGHA: Right.

16   MS. ARAVAMUDHAN: The advantage of

17   using both together is, again, like Dr. Crall

18   pointed out, it's one sealant at one of the

19   four teeth.

20   The thing that we are, we're

21   trying to change provider behavior here, so to

22   track both measures will actually help see if

1 the system is keeping up.

2   MS. ASOMUGHA: Right, okay. Thank

3 you.

4   MS. MUNTHALI: I'm sorry. I just

5 wanted to clarify how we are using the term

6 paired, it is how you described it. So the

7 measures can stand on their own, but have

8 separate scores and that is different from a

9 composite where we would actually have the

10 measures reported together and they have one

11 single score.

12   So the committee could recommend

13 that if they wish, but I'll allow the

14 discussion.

15   MS. CHIANG: So I think, I had the

16 same question. I think that it's just --

17   MALE PARTICIPANT: Turn on the

18 microphone.

19   MS. CHIANG: I actually have the

20 same question and I think it's just to make

21 sure that we're consistent in our response,

22 right?

1   Because, and perhaps it could be

2 because maybe some of were new and really

3 didn't understand the voting process and maybe

4 we changed our answers since between the two,

5 but I had that same concern.

6   MS. ARAVAMUDHAN: If I might just

7 add, as a developer when I went into the

8 forums to submit the forms we had the ability

9 to give them as individual measures and also

10 check off a box to say if we believe that it

11 could be paired.

12   Now we did not check off the box

13 so it's coming to as an individual, but we

14 have no problem, you know, going back and

15 saying, you know, pair these as well.

16   I'm not understanding what it

17 would do to the health system in terms of

18 advocating it as a pair, so I would be, I

19 think we would be okay with having them

20 endorsed individually as well as paired, not

21 just going to the paired option which would

22 force the system to have two measures.

1   I think we don't want that. So if

2   we can look at individual endorsement as well

3   as a paired version if that's okay with the

4   committee.

5   MS. ROBINSON-ECTOR: Overall

6   suitability for endorsement, does the measure

7   meet NQF criteria for endorsement? Note, this

8   may not yet be a recommendation for

9   endorsement.

10   Final recommendation for

11   endorsement may depend on assessment of any

12   related and competing measures. One is yes,

13   two is no, and voting begins now.

14   (Pause)

15   MS. ROBINSON-ECTOR: We're still

16   waiting on one vote. All votes are in and

17   voting is now closed.

18   For overall suitability for

19   endorsement for Measure 2509, Prevention

20   Dental Sealants for 10 to 14 Year Old Children

21   at Elevated Caries Risk, there were 18 votes

22   for yes and three votes for no, so the measure

1   is endorsed.

2   MS. SAMPSEL: Okay, so with that,

3   one, lunch is here, but before we go to lunch

4   we need to open up for a public comment and,

5   Kathy, can you open the lines for public

6   comment please.

7   OPERATOR: Yes, ma'am. At this

8   time if you would like to make a comment

9   please press star then the number one on your

10   telephone keypad.

11   There are no public comments at

12   this time.

13   MS. KHAN: Okay, I believe we're

14   going to take a break for lunch. Everyone is

15   welcome to lunch. So we'll be back here at

16   12:35, 12:45, sorry, a half an hour.

17   (Whereupon, the foregoing matter

18   went off the record at 12:11 p.m. and went

19   back on the record at 12:48 p.m.)

20   MR. MCINERNEY: I want to thank

21   everyone for being so diligent and sitting

22   down again getting ready to go, on time, after

1 a short lunch break.

2   And just before the lunch break,

3 Elisa and Sarah and Adeela and I were

4 remarking that although the voting on the

5 first measure, I think there was some degree

6 of sort of a little confusion and a novice

7 feeling about how the whole process worked,

8 and then we did some explanation and changed

9 a little bit the methodology of voting on the

10 second measure, and I think people felt a

11 little bit more confident about that.

12   But as we looked at the votes on

13 the two measures, they really were fairly

14 similar. So I think we can feel pretty good

15 about the fact that even though we may have

16 felt at times a little uncertain about that

17 first vote, it really came out pretty well.

18   And once we were feeling a little

19 more knowledgeable, we ended up voting pretty

20 much the same way anyway on the second

21 measure. So that, I think, is good. And I

22 know this is, for those who haven't done this

1   before it can be a bit overwhelming.

2   Even though I'd been through the

3   process once before a couple of years or three

4   years ago, it's a pretty rigorous analysis

5   that we're required to do as we go through the

6   algorithms, and it does require a certain

7   amount of discipline to follow the guidelines

8   on how to do the voting and then judge these

9   measures.

10   So thanks everyone for sticking

11   with it, and we'll hopefully, as we move

12   through the afternoon, we'll feel a little bit

13   more confident with each vote, each measure.

14   So at this point we're moving on

15   to Measure Number 2528, the Prevention Topical

16   Fluoride for Children at Elevated Caries Risk,

17   Dental Services. And that is on Page 86 of

18   your measure worksheet. It's actually the

19   last, I think it's the last measure on the

20   worksheet. There are 91 pages on the

21   worksheet if you're on the same worksheet that

22   I'm on.

1   So the brief description of the

2   measure is the percentage of enrolled children

3   age 1 to 21 years who are at elevated risk,

4   that is, either moderate or high who received

5   at least two topical fluoride applications

6   within the reporting year.

7   And who wanted to lead the

8   discussion on this?

9   MS. SAMPSEL: Robert, did you want

10   to start or -- can you use your microphone?

11   And also, I guess, before we do that did the

12   Dental Quality Alliance have any quick

13   comments?

14   MS. ARAVAMUDHAN: I can give you a

15   quick overview of this measure. This is the

16   second preventive service in terms of what we

17   know is dentistry. This is again very well

18   supported by Cochrane Reviews and evidence

19   based guidelines.

20   It has been more than a decade

21   since we know that this works and we're still

22   seeing a performance gap. So hopefully

1 putting a measure in place will help us move

2 that needle forward.

3   The performance at the PC

4 requires, is both reflective of an access

5 problem as well as a performance problem at

6 the provider level in applying these sealants

7 of these fluoride, topical fluorides.

8   The one thing that I would like to

9 state that the measure is very specific to at

10 least two topical fluoride applications,

11 because we have evidence and guidelines that

12 shows that, you know, simply just one

13 application, it's not cutting it.

14   The guidelines definitely talk

15 about applications every three to six months,

16 and so anyone who's identified at a moderate

17 or high we'd like to at least see that two

18 varnish applications each year be met.

19   The risk criteria, the risk logic,

20 everything is the same as the previous

21 measures. The CAPA statistics, the

22 reliability, validity, everything was, scores

1   are all presented and very similar to the

2   sealant measures.

3   MR. MCINERNEY: Okay.

4   MR. BAER: The ambulatory care,

5   clinician office, clinic, is that just

6   dentists or are you including primary care

7   folks who are applying varnish?

8   MS. ARAVAMUDHAN: So this is again

9   a dental services measure like we went, and

10   there is a currently endorsed measure that's

11   a sister measure to this that measures the

12   oral health services.

13   MS. SAMPSEL: Now we'll ask

14   Robert, if you could, using the script that

15   was passed out so we can walk through each

16   criteria in this group and have discussion.

17   MR. VALDEZ: Okay. Evidence. The

18   committee in looking at this has certainly

19   found that there was moderate evidence to good

20   evidence. Although there was some questions

21   about the degree to which studies supported

22   this particular measure, its focus, it follows

1   ADA recommendations that were supported by

2   systematic review.

3   Did you want to do one? All of

4   them?

5   MR. MCINERNEY: I'd like to make

6   just one comment. There are pediatricians in

7   the country who will apply dental fluoride

8   especially for Medicaid patients. For

9   pediatricians, it's one of the few procedures

10   that we can do and get paid for.

11   And so not only because it's the

12   right thing to do, but also because we get

13   paid for doing it, some pediatricians who have

14   a high proportion of Medicaid patients will

15   apply dental sealants.

16   So what I'm a bit concerned about

17   with this measure is as you're looking at the

18   measure, if a child has had dental sealant

19   twice a year in a pediatrician's office, how

20   is that recorded or you just miss those?

21   MR. CRALL: I would say Dr.

22   McInerney, with the use of this measure it

1   would not look at those children. However, as

2   I showed on the initial slide, with what we

3   know from CMS and Medicaid data at least up

4   this point in time that applies to about four

5   percent.

6   And as you well know, most of the

7   programs around the country, across the

8   states, are really emphasizing sort of the

9   birth to three years or perhaps just a bit

10   beyond for the pediatrician again trying to

11   take advantage of the periodicity schedules

12   around well child visits and immunizations and

13   all those encounters that occur.

14   As we pointed out, we have a

15   parallel measure for this that is the oral

16   health as well as a measure that looks at

17   both. So we fully embrace the concept of

18   applying all those measures. This is the only

19   one we got the form completed on and filled

20   out up to this point.

21   MS. ARAVAMUDHAN: If I might add a

22   little bit more is as we worked through our

1 committees and, you know, figured out what to

2 submit, we were also weighing the decision of

3 as a health system who should be held

4 accountable for this, which portion should be

5 held accountable.

6   The second thing we were thinking

7 about is typically for, especially when you

8 look at risk status, we would like for the

9 pediatricians to assess the risk and give the

10 varnish and then refer.

11   So if you go to this thing about

12 two fluoride varnish applications, then whom

13 are you putting the burden on? Those were

14 some of the discussions that went on.

15   The pediatrician, the oral health

16 service measure that's currently endorsed

17 simply asks for one application which is fine.

18 So there are many who wants us to consider

19 whether taking this for both systems was

20 needed or not.

21   MR. CRALL: And I guess just to

22 add because Krishna's comment just triggered

1   a thought. So you have the already endorsed

2   measure that looks to capture it on the

3   primary care side, and then with this measure

4   would add the capturing it on the dental side.

5   And then obviously, I mean we

6   fully encourage, you know, programs to try to

7   look at both of those measures to understand

8   what was going on in both segments of their

9   delivery system.

10   MR. MCINERNEY: Make sure the

11   patients aren't falling through the cracks

12   between the two.

13   MR. VALDEZ: Tom, we had a long

14   discussion in the working group around this

15   issue, because the real question was what are

16   we really interested in? Are we really

17   interested in whether the kids got the

18   services that they required and needed, or are

19   we more interested in sort of which provider

20   was actually providing it or getting paid for

21   it?

22   And I think there's a great

1   concern that by splitting up measures like

2   this we weren't really looking at the priority

3   of looking at whether or not the children were

4   getting the services they needed even at the

5   programmatic level, and potentially limiting

6   delivery models that would use alternative

7   ways of providing the services.

8   MR. MCINERNEY: So do we have any

9   further discussion on the 1a, the evidence to

10 support the focus? Yes?

11   MR. AUERBACH: I wonder if you

12 could talk about the rationale of the age

13 group? 1 to 21 is a very broad age group and

14 it transcends some definition of pediatrics

15 and may affect insurance coverage as well.

16 And so maybe you could just talk about why

17 that age range is selected.

18   MS. ARAVAMUDHAN: Sure. I'll

19 start first and maybe Dr. Crall can add on.

20 The 21 mark is what CMS used to define a

21 child. So all our measures are for 21 simply

22 because of how Medicaid programs define a

1 child.

2   We do have a clause within the

3 user guide that in the exchanges marketplaces

4 HHS has chosen to define a child as under 19.

5 So the child cut-off, really, because these

6 are program-level measures, it depends on what

7 the program defines as a child in terms of

8 benefit coverage. So the 21 is what the

9 Medicaid programs and CMS uses as its

10 definition for a child.

11   MR. CRALL: Yes, so I think that

12 is the rationale for why that particular span.

13 Within our measures, we also promote the

14 notion of stratification by age, and we

15 basically adopted the same stratifications

16 that CMS uses in the 416 EBSDT report.

17   So that you can actually, you

18 know, that programs that once they get beyond

19 just an aggregate measure if they're really

20 trying to understand, you know, whether or not

21 services are being provided across a fairly

22 broad age span like 1 to 21, if you really

1   wanted to know, are the preschool age kids

2   getting it and at what rate? Are the

3   elementary age kids getting it? Are the

4   adolescents getting it?

5   Our measures encourage the use of

6   stratification by age and some other factors

7   that would help understand the delivery across

8   that relatively large age span that you're

9   highlighting here.

10   MR. AUERBACH: So I would just

11   say, I wonder if you could maybe talk about

12   the downside of a measure that's 1 to 21. I

13   would say, you know, as somebody who's worked

14   in government for awhile, CMS may consider

15   children up to 21 to be potentially eligible,

16   but once children are independent of their

17   parents and through their parents' coverage

18   they're not covered on, many children 18 and

19   older or even, you know, younger than that are

20   no longer covered on their parents' Medicaid.

21   So, you know, many are not, change doctors,

22   it's a complicated system.

1   So I guess just view, I wonder if

2   you've considered that from a data collection

3   perspective there are challenges that arise

4   when you've got that, that we should note that

5   when you have that broad of range of age.

6   MR. CRALL: I'll start out, and it

7   actually reminds me of a brief discussion we

8   were having at the lunch break.

9   So I think, you know, the

10   guidelines clearly talk about caries and

11   caries risk being applicable across this broad

12   age range, so, and in fact, you know, some of

13   the probably more dated thinking really

14   focuses around dental caries being a disease

15   of childhood and not of adulthood.

16   So from the standpoint of the

17   evidence and from the standpoint of the

18   mechanisms that we currently have for managing

19   or reducing or controlling the risk of dental

20   caries, not, you know, eliminating the risk

21   for dental caries over time, we think it's

22   important that individuals again identified as

1 a high risk regardless of their age throughout

2 this spectrum, this age spectrum, that that

3 should trigger the more intensive application

4 of topical fluoride.

5   So for that reason we use the 1 to

6 21 to sort of set the entire boundary of the

7 measure. I mean we could bring you five

8 different measures that sliced it by age

9 groups, but I don't think that that would

10 necessarily add anything.

11   And the way that we have tried to

12 accommodate that in all of our measures is to

13 encourage the, look at the analysis of what

14 the data tell you, stratifying by age group.

15   MR. VENKATESH: I guess building

16 on this age question, I was just looking

17 through your evidence submission form, and you

18 have the evidence rated as moderate with the

19 kind of reference as being to evidence that's

20 limited 6 to 18 years of age.

21   And so I guess my question is, if

22 the evidence is for 6 to 18 and a measure that

1 was 6 to 18 could still be used for

2 accountability purposes in any CMS program, I

3 don't think that the CMS program would require

4 you have to have a measure that goes to 21,

5 and it would be able to be used in a

6 marketplace plan.

7   Would it just be more consistent

8 with the evidence and more a reduced

9 measurement burden to have a measure that was

10 that age range?

11   MS. ARAVAMUDHAN: So I can tell

12 you from the guidelines work that again the

13 age range of 18 was picked based on the

14 commercial plans, and that was the way, you

15 know, most of the marketplace is commercial so

16 we picked the 18 for the guidelines.

17   But if you look at the

18 recommendations, the strength varies from 6 to

19 18 and 18 on forward but the recommendations

20 are still the same in terms of, you know, how

21 frequently fluoride applications need to be

22 done for the high and moderate risk.

1   So the recommendations, per se,

2   don't vary. The strength of the

3   recommendations vary. I will also tell you

4   that our current measure description, sort of,

5   what we'd like to do is for the programs to be

6   able to use the best measure they need, and

7   CMS/Medicaid was what was really looking for

8   this measure.

9   MR. VENKATESH: And I would add, I

10   think, you know, using an age range like 6 to

11   18, actually, would actually send the wrong

12   message.

13   I mean we are doing everything we

14   can to increase the emphasis on early

15   childhood caries and understanding that it's

16   not whether there are primary teeth or whether

17   there are permanent teeth that are affected,

18   that's it's the underlying disease process

19   that needs to be dealt with. And so starting

20   at 6 would actually set up back, I think,

21   considerably.

22   MR. BIALEK: I'm wondering if we

1   could speak a little bit to the efficacy of

2   the two applications per year for this entire

3   population. Because I'm looking at an ADA

4   article that suggests that for under the age

5   6 it's not necessarily effective. And I'm

6   just wondering if you can speak to it.

7   And I'm maybe, I'm just going

8   through this stuff really quickly, but, you

9   know, what is the evidence based on? I know

10   about the caries piece, but the efficacy of

11   the intervention for this whole population.

12   MR. CRALL: There are individual

13   articles that either because of the design or

14   the population focus or whatever, certainly

15   the summaries of studies that have been done

16   in multiple populations sometimes with

17   slightly different age groups, et cetera,

18   generally will differentiate for the

19   effectiveness in primary teeth versus

20   permanent teeth, and that brings in the age

21   group piece.

22   You know, again it's much more

1 common and historically has been more common

2 for topical fluorides to be used in older

3 children simply because we haven't served the

4 younger population as well as we could.

5   But the evidence is not that

6 dissimilar in the consensus in terms of the

7 overall effectiveness on topical fluoride

8 applications at this intensity for whether the

9 effect is on permanent teeth or primary teeth.

10 Some variation, yes, but overall generally

11 considered to be effective.

12   What, sometimes there, you know,

13 where some efforts have been made recently to

14 look at some systematic analysis of different

15 types of providers, sometimes that evidence

16 softens up a bit just because it's a

17 relatively recent phenomenon of engaging those

18 other than dentists in the delivery.

19   But by and large not, you know, a

20 radical difference in terms of the overall

21 effectiveness of topical fluoride on caries

22 whether it be in primary or permanent teeth.

1   MS. ARAVAMUDHAN: And if I might

2   add, the clinical recommendation, I'm trying

3   to pull it up on my phone really quick, but it

4   does go to the younger age group. It doesn't

5   start at 6 to 18.

6   And I'd also like to point out

7   that the reason why pediatricians are paid

8   for, reimbursed and encouraged to do this is

9   because, you know, it is effective in the

10   younger age ranges as well.

11   The United States Preventive Task

12   Force Service came out with a draft for

13   recommendations which is available right now

14   that again promotes the use of topical

15   fluoride varnish.

16   MR. BIALEK: So in the

17   documentation that you submitted I didn't see

18   that in there. Again maybe I am missing it.

19   But you provided the evidence about the

20   efficacy for the age group that the measure

21   applies to? That's in there where there is

22   documentation of the efficacy?

1   MS. ARAVAMUDHAN: Let me get my

2   computer really quick and take a look at that,

3   but I can tell you that the guidelines do

4   recommend younger than 6 years old and it is

5   a recommendation for red varnish at least

6   every three to six months.

7   Oh, there is, Jill just pointed me

8   to the evidence summary form under Section

9   18.7.7, the recommendations 2.26 percent for

10   red varnish at least three to six months for

11   children younger than 6 years, and then

12   varnish or gel for children 6 to 18. So both

13   of them are referenced.

14   MS. CHIANG: I have a question

15   about feasibility and efficacy. So I also

16   have this concern about the large age range

17   because usually pediatricians don't recommend

18   you go to a dentist when you're a year old.

19   So if you have this, and then also

20   there's the transition period between 18 to 21

21   where we know that this cohort, at least for

22   the other ADA, the diabetes group, we know

1 that they kind of fall off and neglect their

2 health care.

3 So I have a question about

4 feasibility, how you would actually implement

5 this in those age cohorts and then how

6 feasibility would impact efficacy. So how do

7 you know if you're not getting good results

8 because it's not effective? Because one thing

9 that I also don't understand is in age

10 development, different age cohorts have

11 different, you know, growth and development

12 impacts them.

13 And so at each stage it's a little

14 bit different. I don't know how it is in

15 teeth, but I'm assuming it's the same. So

16 perhaps it's more effective less than 6 years

17 old. But I just don't understand. If you

18 don't define that then how do you know?

19 You have two things. One is the

20 feasibility problem. How do you know that

21 that's not going to impact the efficacy

22 problem? Does that make sense? So if you

1   don't have it divided up into age cohorts for

2   the feasibility and you get poor efficacy, how

3   can you distinguish between those two?

4   MR. CRALL: Okay. So I think what

5   I'm hearing in these questions, so if you only

6   had, let's say you used sort of the current

7   CMS approach and you included, you know, all

8   the age groups into one aggregate measure

9   that's obviously going to have a whole variety

10   of elements that go into giving you that one

11   aggregate measure.

12   And again, so no one measure is

13   going to really sort of be able to untangle

14   that. The options you have then are basically

15   to design measures around very narrow age

16   groups or to promote people to actually use

17   the data that come in to provide the

18   information on the aggregate measure and to

19   stratify and to look within those age groups.

20   That's clearly feasible through the reporting

21   mechanisms that are inherent in this measure.

22   You know, I was part of a group

1   with Mathematica that just completed a tool

2   kit for states how to use their data better

3   and to go beyond just the use of those

4   aggregate measures. CMS supported that work.

5   So there, clearly, we're trying to

6   move the field in that direction. And that's

7   the current mechanism that's currently,

8   basically, being employed, to say, you know,

9   we have an aggregate measure. It's got a

10 historic precedence.

11   It does show considerable

12 variation across state programs at least and

13 differences between different segments of the

14 population, but it in the aggregate itself,

15 you know, it's going to have a lot of

16 different underlying components, one of which

17 we know is age.

18   And to your point in terms of

19 caries risk, you know, one of the major

20 factors in caries risk is the composition of

21 the bacteria and the amounts of certain types

22 of bacteria.

1   The other that's going to vary

2   very much, and I think on a developmental

3   stage, is going to be things like diet which

4   is another major sort of significant

5   component.

6   Really, you know, there's a

7   clinical science aspect of that that needs to

8   be developed, but in the measures world, I

9   think, using age stratification is probably as

10   good as we're going to get at this stage of

11   the ability to collect data and to report it

12   and analyze it.

13   MS. CHIANG: Yes, so thank you. I

14   think the reason why I'm asking these

15   questions because that impacts how I'm going

16   to vote, and the feasibility versus the

17   validity of the recommendation.

18   MS. ARAVAMUDHAN: And if I might

19   just add on, if you look at feasibility from

20   a data collection standpoint, again all these

21   are standard CDT codes, very similar to the

22   previous measure so it will be collected.

1   In terms of the younger age group

2   where you mentioned, you know, pediatricians

3   referring, there is a Bright Futures guideline

4   which says, you know, refer, especially when

5   you do the risk assessment. AAP is definitely

6   behind risk assessment. Do the risk

7   assessment and refer.

8   So that is part of the Bright

9   Futures guidelines, so part of this measure

10   will be to promote within the system that

11   interaction between the medical-dental field

12   to make this happen as a system.

13   There are about 108 million kids

14   who see the physician and don't see the

15   dentist, 27 million that see a dentist don't

16   see a physician. So there's a lot of, you

17   know, coordination that can happen between,

18   and we're hoping that measures like this will

19   actually promote that kind of referral and a

20   dental home being established.

21   MR. VENKATESH: I guess sort of

22   related to the under age 6 age group there's

1   a line in here, where in the consensus

2   guidelines they conclude that for the under 6

3   age group the only fluoride that would be

4   recommended is the 2.6 percent and that for

5   the other forms the harms would outweigh the

6   benefits.

7   Will the measure be able to

8   incorporate that in, or is there, could you

9   potentially in that under 6 age group have

10 high performance but be giving fluorides that

11 are potentially harmful?

12   MS. ARAVAMUDHAN: The use of

13 varnish is probably the most prevalent. The

14 gel, and Dr. Inge can comment on this in terms

15 of the claims they receive, it's really very,

16 very low in terms of how much it's used. The

17 coating as such does not discriminate between

18 the type of fluoride that's applied, but

19 varnish is the most common that's used.

20   MR. MCINERNEY: Okay, if there are

21 no further questions we should -- oh.

22   MR. VALDEZ: I was just wanting to

1 make sure, because our conversation went

2 beyond our script. So I was just following

3 along and letting it go because the

4 conversation is probably the most important.

5   But your script has us voting

6 evidence and then I was going to talk about

7 something else and then we're going do another

8 vote before we even leave 1. Okay, just

9 checking.

10   MR. MCINERNEY: Okay. So we'll

11 vote on the evidence. Kaitlynn, could you put

12 that evidence on, please?

13   MS. ROBINSON-ECTOR: Importance to

14 measure and report 1a, evidence. Importance

15 to measure and report 1a, evidence structure,

16 process and intermediate outcome. 1 is high,

17 2 is moderate, 3 is low, 4 is insufficient

18 evidence, 5 is insufficient evidence with

19 exception. Voting begins now.

20   We're still waiting for one more

21 vote. Okay, we now have all of our votes and

22 voting is closed. For evidence, there were

1   two votes for high, 15 votes for moderate, one

2   vote for low, one vote for insufficient

3   evidence, and one vote for insufficient

4   evidence with exception.

5   MR. VALDEZ: Our next voting area

6   is looking at opportunity for improvement.

7   We'll have some presentation and then

8   discussion.

9   The presenters, or the developers

10   presented data that was fairly convincing to

11   the committee, or to the workgroup, that there

12   were, in fact, disparities in oral health

13   status and in the use of oral health services

14   such as these.

15   The evidence was also presented

16   about disparities by race and ethnicity,

17   geographic location and other factors that

18   were using data from several Medicaid and CHIP

19   programs in the state of Texas and in Florida

20   where they demonstrated both the differences

21   among the individuals but also among the

22   different programs. The evidence was

1   considered moderate by the workgroup.

2   MR. MCINERNEY: Thank you. Any

3   discussion on this measure? Okay.

4   MS. ROBINSON-ECTOR: Importance to

5   measure and report 1b, performance gap. One

6   is high, 2 is moderate, 3 is low, and 4 is

7   insufficient. Voting begins now.

8   Still waiting for one vote. Now

9   all of our votes are in, voting is closed.

10   For performance gaps there were six votes for

11   high, 14 votes for moderate, zero votes for

12   low, and zero votes for insufficient.

13   MR. VALDEZ: The next area is

14   priority, and this measure clearly looks at

15   whether or not children over a wide range, 1

16   to 21, are in fact receiving a service that is

17   preventive in nature.

18   And most of the workgroup

19   committee members thought that in fact this

20   was an important issue, however, there was

21   some question whether or not there are other

22   sources of fluoride that in fact could serve

1 similar kinds of preventive needs in

2 populations that may or may not be accounted

3 for.

4   And the question was raised about

5 whether or not there was simply this kind of

6 service, but everybody was in fairly good

7 accord that this was a high priority issue.

8   MR. MCINERNEY: Any further

9 discussion on priority? Okay, Kaitlynn, let's

10 do the vote please.

11   MS. ROBINSON-ECTOR: Importance to

12 measure and report 1c, high priority. One is

13 high, 2 is moderate, 3 is low, and 4 is

14 insufficient, and voting begins now.

15   And we're waiting for one more

16 vote. We now have all of the votes and voting

17 is now closed. There were 13 votes for high,

18 seven votes for moderate, zero votes for low,

19 and zero votes for insufficient.

20   MR. VALDEZ: The next section that

21 we're taking up has to do with reliability

22 regarding specifications and reliability

1   testing. The measure is well defined, relies

2   on the same data we've been talking about all

3   morning and afternoon.

4   The reliability testing also is

5   considered of high value and came across from

6   multiple programs as well as looking at

7   different time frames.

8   MR. MCINERNEY: Any further

9   discussion on this measure? Yes, John?

10   MR. AUERBACH: You know, this is a

11 situation where I am concerned about the age

12 range. And so I would be, I'm torn about sort

13 of voting favorably versus not, just because

14 I would feel more comfortable if it was a

15 range that was narrower.

16   So that's more of an observation

17 and I guess the guidelines would just be

18 struggle with that and come out with what you

19 feel is the right vote. But since you were

20 saying you wanted some notation on what people

21 were observing, I just wanted to say that that

22 was one of those things that is challenging.

1   MS. MUNTHALI: We'll make sure we

2   capture that in the report. Perhaps you could

3   also make a recommendation that the next time

4   the measure is up for maintenance review, you

5   know, the developer could change age of the

6   age range or now or whatever the guidelines

7   are saying, because it is supported by the

8   guidelines.

9   So I guess the committee can

10   discuss that, if you'll allow that, Tom and

11   Sarah.

12   MS. SAMPSEL: Is that something

13   the committee would like to recommend? Eric,

14   did you have a comment on the age issue?

15   MR. BAER: I have a comment.

16   MS. SAMPSEL: Okay.

17   MR. BAER: With respect to the

18   age, I live in the Medicaid world therefore

19   this is the age group that is defined and this

20   is the age group. That aside, would changing

21   the age range have any effect on harmonization

22   with other efforts? Meaning, you know, a lot

1   of the CMS -- maybe I'm not sure. I'm brand

2   new to this.

3   I'm not sure what harmonization

4   is, but if it's bumping it up against other

5   measures that might be out there already, CMS

6   has a lot of measures out there already for

7   this EPSDT age range which happens to be up to

8   the age of 21. So, starting at 1. Yes.

9   MS. SAMPSEL: That's a really

10 important consideration is that consistency

11 and harmonization across other measures

12 looking at that same population, so that's a

13 very good point.

14   MR. SALIVE: Well, I didn't hear a

15 compelling reason to change the age range, so

16 I'm speaking against that. I mean I think,

17 you know, there's a lot of recommended

18 treatment with these topical fluorides under

19 the age of 6 that I saw, and so it seems like

20 why are we going to tinker with this?

21   MR. FRANCE: Well, at the risk of

22 going to a different area, I was looking at

1   the validity issue versus reliability and

2   concern about missing data.

3   So it doesn't capture of course

4   what's happening in pediatrics, and so if it's

5   supposed to be a reflection of the use of

6   varnishes among children or is interpreted as

7   such, it will underestimate its use since it's

8   not harmonizing or summing with what's

9   happening in pediatric and the medicine

10   offices.

11   MS. ARAVAMUDHAN: Again I want to

12   go back to Dr. Crall's comment. We had to

13   balance this need to capture everything versus

14   make the measure usable for a Medicaid program

15   where the financing system is different

16   between medical and dental.

17   As Dr. Crall pointed out, the kids

18   who actually only get oral health services is

19   simply three percent of the population. So

20   given that our focus was, okay, taking that

21   into consideration, do we want a usable

22   measure that programs can use and report on

1   and actually be comparable broadly between

2   Medicaid, commercial and such?

3   And so that's the reason why we

4   said, you know what, this is the way to go.

5   MR. MCINERNEY: If I remember our

6   guidelines, we are supposed to vote on the

7   measure as it has been specified. I don't

8   think we're allowed to change the measure at

9   this point. We can recommend that in the

10   future the measure be changed. Is that

11   correct?

12   MS. BURSTIN: At times when there

13   are sort of very narrow things that come up in

14   committees, that can be a negotiation between

15   the developer and the committee. But

16   obviously narrow things with complete

17   agreement on both sides.

18   MR. BIALEK: It looks like the

19   workgroup raised a couple of validity issues

20   beyond the age group. And there's a statement

21   in here that says, workgroup members ranked

22   the measure low against the validity

1   criterion. And I'm wondering if the workgroup

2   can speak to that.

3   MR. VALDEZ: That's our next topic

4   and discussion for voting. We're focused on

5   reliability.

6   MR. MCINERNEY: We'll do the

7   reliability first, then we'll move to --

8   MR. BIALEK: No problem.

9   MR. MCINERNEY: -- validity.

10   Okay, I think then we're ready to vote on

11   reliability. Please, Kaitlynn?

12   MR. VENKATESH: So it is a

13   reliability comment as I think about it. In

14   Table 1b.2, you show the performance scores by

15   year. And so when I look at Program 3 from

16   2010 to 2011, it drops 13 percent, from 35 to

17   22. But then when I look at Program 2, for

18   example, it goes up 5, from 22 to 27. Those

19   seems like widely divergent directions for

20   something that's been coded the same between

21   years.

22   And so I'm wondering how reliable

1 the codes are for the measure, and this gets

2 to a little bit of, this is why I wasn't sure

3 whether to put it in the reliability or the

4 validity side of this. But should we be

5 concerned that we're not measuring what we

6 think we're measuring there?

7   MS. ARAVAMUDHAN: Could you please

8 point out which form you're looking at? Is it

9 the measure testing form?

10   MR. VENKATESH: The measure

11 testing form, sub-criteria 2a2 to 2b2 to 2b6,

12 that one.

13   MS. ARAVAMUDHAN: Okay, let me get

14 there.

15   MR. VENKATESH: My concern is that

16 it just jumps so much within a year and in

17 different directions that it's not measuring

18 what it thinks it is.

19   MS. LUCK: What page are you on?

20   MR. VENKATESH: Seventeen of 18.

21   MS. ARAVAMUDHAN: So we see that

22 in our submission under the section under

1   reliability we don't have any tables listed.

2   MR. VENKATESH: You have it listed

3   under validity. And we want to move the

4   discussion to there, that section, we can have

5   it in that part. I'm fine with that, unless

6   it's because of something you think has

7   something to do with the testing on the

8   reliability side. That's why I asked the

9   question that way.

10   MR. CRALL: Okay, sorry. I think

11   we found the table. Can you just restate that

12   please?

13   MR. VENKATESH: Sure. So Program

14   3 in 2010 has a 35 percent score, right, and

15   then in 2011 drops to 22 percent. It's a big

16   change downwards. Program 2, for example,

17   though in 2010 has a 22 percent score, and in

18   2011 jumps up by five percent.

19   And so when I see fairly large

20   magnitudes of change going in divergent

21   directions, I'm wondering how reliably it's

22   measuring the underlying construct.

1   And so is it because one of those

2   programs did a quality improvement effort and

3   the other one did not? I mean do we have any

4   background context as to why that would

5   happen, or is it simply that there's that much

6   noise in the data year to year?

7   MR. CRALL: Well, I may have

8   always been, but I'm clearly right now, I'm

9   completely blind as to what those programs

10 represent. Jill may actually know what

11 programs there are.

12   I think the fact that in two out

13 of the three they were fairly similar and, you

14 know, there was an incremental increase from

15 the 2010 to the 2011 year certainly speaks,

16 you know, gave us some degree of confidence

17 that in fact that they're measuring in a

18 fairly reliable way.

19   The reason for that difference in

20 that one program from one year to the next, I

21 personally am not sure what that is, you know,

22 the reason for that. Jill, do you happen to

1   know what Program 1, 2, and 3?

2   (Off microphone comments)

3   MR. CRALL: Okay, 1 is Texas

4   Medicaid, 2 is Florida CHIP, 3 is commercial.

5   So the one thing that I know in terms of the

6   testing is that the data we had for commercial

7   actually is relatively small.

8   You know, we actually, we wanted

9   to bring that in even though that isn't the

10   primary sort of data source that the

11   contractor had available, but we did want to

12   bring in some information from a commercial

13   side to look at, test it across all the

14   different sectors.

15   So it possibly is a small numbers

16   piece that could differ from one year to the

17   next. If it had gone the other way I don't

18   think it would have even been quite so much of

19   a concern. Whether or not there's some policy

20   changes in that commercial plans or whether

21   the composition of those commercial plans that

22   are aggregated there change from one year to

1   the next, I don't know. We don't know.

2   So the composition within the CHIP

3   program and within the Medicaid program, the

4   other two that held fairly consistent, I

5   think, would be reasonably consistent over

6   years. But the composition of what's in the

7   commercial one may introduce the variability.

8   MR. MCINERNEY: Okay, I think

9   we're ready for the vote. Kaitlynn, please?

10   Thank you.

11   MS. ROBINSON-ECTOR: Scientific

12   acceptability of measure properties

13   reliability. One is high, 2 is moderate, 3 is

14   low, and 4 is insufficient. And voting

15   starts.

16   We're still waiting for two votes.

17   We have all of the votes. And there were 15

18   votes for high, 13 votes for moderate, three

19   votes for low, and one vote for insufficient.

20   MS. KHAN: I think it's three

21   votes for high. Yes.

22   MR. VALDEZ: Okay, now we get to

1 take on validity, which was the question

2 several people brought up in our last

3 discussion and rightly so, because the

4 workgroup also had some concerns on the

5 validity side.

6   Most of it, I'm going to cut to

7 the quick, were around the confidence that the

8 performance measure, in fact, was a valid

9 indicator of quality. And in large part

10 because most of this was on professional

11 guideline recommendations and not on any

12 studies that we had presented, as I recall.

13   But David, you'll have to help me

14 on this one because my memory is failing.

15   MR. MCINERNEY: Do you have a

16 comment on validity, Arjun? No further

17 comments on validity? All right. Oh, I'm

18 sorry, you do.

19   MS. ARAVAMUDHAN: Yes, sorry. I

20 do want to talk about the fact that in our

21 evidence forum in terms of the comment about,

22 you know, connection to the outcomes, we did

1   talk about the Cochrane Reviews as well as the

2   evidence based guidelines.

3   We did include an image from the

4   Cochrane Review which had run a meta-analysis

5   to show the impact on the outcome. So just

6   wanted to put that on the table. Thank you.

7   MS. ROBINSON-ECTOR: For validity,

8   1 is high, 2 is moderate, 3 is low, and 4 is

9   insufficient. You can start voting.

10   There's one vote for high, 11

11   votes for moderate, seven votes for low, and

12   one vote for insufficient.

13   MS. MUNTHALI: So what we're

14   discussing is what we need to reach consensus,

15   and so we're just at that low threshold of 60

16   percent and so we will proceed.

17   MR. MCINERNEY: Okay.

18   MR. VALDEZ: The next section is

19   feasibility. The designers demonstrated that

20   it was feasible using data from multiple

21   programs, multiple states, and commercial

22   plans using the data that we've been talking

1   about all afternoon. So the workgroup had no

2   additional comments to make.

3   MR. MCINERNEY: Any discussion on

4   the feasibility? Okay.

5   MS. ROBINSON-ECTOR: For

6   feasibility, 1 is high, 2 is moderate, 3 is

7   low, and 4 is insufficient. And voting starts

8   now. All the votes are in and voting is now

9   closed. For feasibility there were ten votes

10   for high, ten votes for moderate, zero votes

11   for low, and zero votes for insufficient.

12   MR. VALDEZ: The next section is

13   usability and use. The measure is currently

14   in use in Texas and in Florida in

15   Medicaid/CHIP programs, and I think it was

16   also a commercial plan. There was no

17   information particularly presented with regard

18   to improvement over time and there were no

19   other additional comments by the workgroup.

20   MR. MCINERNEY: Any further

21   comments on usability? Okay, Kaitlynn, let's

22   vote these.

1   MS. ROBINSON-ECTOR: For usability

2   and use, 1 is high, 2 is moderate, 3 is low,

3   and 4 is insufficient information. And you

4   can start voting. Okay, we now have all of

5   our votes and voting is closed.

6   For usability and use there were

7   six votes for high, ten votes for moderate,

8   two votes for low, and two votes for

9   insufficient information.

10   MR. MCINERNEY: Okay, are we ready

11   to vote on the whole measure as a pass or no

12   pass for endorsement? Any further comments on

13   this measure before we vote?

14   MS. MUNTHALI: We just wanted to,

15   before you vote on overall endorsement if you

16   had any comments, since feasibility was split

17   50/50, we would like to reflect any viewpoints

18   that you would like us to include in the

19   report, if there are any comments for the

20   committee.

21   MR. VENKATESH: I would just add

22   that on 4b, I think, is the criteria about

1   improvement and progress and we only have

2   those two years of data. And so if, in fact,

3   it's not because of substantial differences in

4   the populations between the two, it's very

5   possible that we don't know from actually

6   monitoring progress when you see change

7   between two years.

8   And so I would say in the report

9   that this is a measure that needs a lot of

10   surveillance to see what the pattern is in a

11   fixed or more set to find a denominator over

12   time. Because if it continues to have that

13   much noise to it, it really wouldn't meet

14   criteria.

15   MR. MCINERNEY: Any other

16   comments? Kaitlynn?

17   MS. ROBINSON-ECTOR: Overall

18   suitability for endorsement, 1 is yes, and --

19   MS. CHIANG: I think that the

20   program itself makes sense. I just am

21   concerned about some of these things that

22   we're discussing.

1   So I guess I would like to hear

2   some of the thoughts of maybe some of the

3   other committee members, or maybe the

4   developers could provide a little bit of

5   guidance.

6   I don't know if the other people

7   feel that way, but I personally think that

8   this is a good program but I have concerns

9   about that, some of the things that we've

10 discussed.

11   MR. CRALL: Along the last point

12 that was raised, clearly these measures

13 generally are looked at for longer trends than

14 just from one year to the next.

15   And I think the first thing either

16 CMS or a state Medicaid program, or anyone who

17 is in a position of being held accountable, if

18 they saw a significant change in reporting

19 from one year to the next in terms of

20 performance, the first thing they would do, I

21 would think, would be to question data

22 quality, and was there systematic in the input

1   of the data that, you know, perhaps omitted

2   something from one year to the next.

3   In the examples that we had, we

4   had again, we had a Medicaid program that the

5   population's fairly consistent over time and

6   the administration of the program. We have a

7   CHIP program that is consistent over time.

8   The one piece that we had which

9   showed a significant change from one year to

10   the next was in an aggregate of commercial,

11   which is sort of an artificial sort of sector,

12   really, that we created.

13   I mean it's an important sector,

14   don't get me wrong, in terms of what I'm

15   saying, but that I think that, you know, that

16   longer trend analysis, it's a very valid

17   point. You don't look at these things from

18   one year to the next and make those decisions.

19   The other important part is that

20   if you take it down the next level then,

21   clearly, I think, at a program level, if

22   you're using contractors to administer the

1 benefits, what you're looking for is variation

2 across the various plans who are contracted to

3 administer those benefits and capture a

4 variation there is important.

5   But again, looking in one year, I

6 don't think people are in a decision making

7 capacity looking to go from one year to the

8 next. Generally there is a longer time period

9 where you would be able to make sure that the

10 data, all the data was entered in and that it

11 was truly a difference or a change in

12 performance or the impact of some policy

13 change as opposed to just a data submission

14 issue.

15   MR. AUERBACH: Just in this spirit

16 of making recommendations for the future, I

17 would say if this comes, when this comes up

18 again I would really look at that age

19 indicator. I think what you're going to find

20 is it's a very different Medicaid population

21 when you get into the teen years because

22 Medicaid eligibility is only due for children

1   who are dependent.

2   And what you see in the drop-off

3   of the numbers is you're just measuring a

4   really different cohort under Medicaid in the

5   upper teen years. And so the ones who are

6   eligible then tend to be more disabled because

7   they're not out in the work force and

8   independent.

9   And so, but measure it. I mean,

10   you know, if it's too late to sort of figure

11   that out, I would just say pay attention to

12   that so that you don't, because I think what

13   we'll find is Medicaid directors discount

14   those upper years and just say these are not

15   the same. It's not the same cohort we're

16   measuring.

17   So I think if we pay attention to

18   that, well, maybe the next time it comes up

19   you can adjust for that.

20   MS. ARAVAMUDHAN: Definitely from

21   a developer standpoint these are all extremely

22   useful comments. I'm taking notes in terms

1 of, you know, the age cohorts as well as the

2 question about monitoring over time and

3 seeing, really, how the measure does. So

4 we'll definitely keep that in mind.

5   MR. MCINERNEY: I think we can say

6 -- oh. Go ahead, Ron.

7   MR. BIALEK: I just wanted to

8 raise the potential harm, just put it out

9 there, and this may be overstating it but I

10 just want to put it out there.

11   That when you have an aggregate

12 population like this and if you start holding

13 the plans accountable for increase in the

14 percentages, you may encourage the plans to

15 reach out to those who are easiest to reach,

16 both age group as well as socioeconomic group

17 as well as race and ethnicity, et cetera. So

18 you could actually increase your percentage,

19 and at the same time increase your disparity,

20 but be hiding the disparity here because we

21 have such a large group.

22   And I just wanted to put that out

1   there because I think it's an important

2   consideration for us.

3   MR. MCINERNEY: That's a great

4   point, Ron. And I think hopefully as you're

5   going forward in time you'll try and observe

6   and see if you can see that effect by looking

7   at the sociodemographic characteristics of

8   those who've had the varnish applied and those

9   who haven't.

10   As I hear the discussion I have a

11   perception that many folks feel this is a

12   somewhat immature measure that needs some work

13   and some time for us to be feeling it's a

14   little bit more reliable.

15   But I don't think that should

16   influence our vote tremendously, it's just

17   something for the developers to note. So if

18   there's no further -- oh, I'm sorry. David?

19   MR. KROL: Just to respond to Ron.

20   Though the approach, since all of these

21   children are at risk, at elevated risk, you'll

22   still be reaching out to kids with elevated

1 risk.

2   So yes, there may be some. So say

3 I target a certain subset of children at

4 elevated risk, I'm still targeting children at

5 elevated risk. It's not like I would target

6 the well and versus the unwell, or the

7 diseased versus the not diseased.

8   That's not an issue here, and that

9 I'd be much more concerned about than say, you

10 know, I want to try to reach the kids that

11 aren't being reached but are at high risk.

12 It's a subtle but extremely important, you may

13 still find disparities within those at

14 elevated risk, but they're all at elevated

15 risk.

16   MR. MCINERNEY: Okay, Kaitlynn, I

17 think we're now ready for the final vote on

18 this measure, please.

19   MS. ROBINSON-ECTOR: Overall

20 suitability for endorsement, 1 is yes and 2 is

21 no. And you can now vote.

22   Now have all of the measures and

1   voting's closed. For suitability for

2   endorsement there were 17 votes for yes and

3   three votes for no. So for Measure 2528

4   Prevention Topical Fluoride for Children with

5   Elevated Caries Risk, Dental Services, the

6   measure passes.

7   MR. MCINERNEY: Okay. We're now

8   moving to 2511, Utilization of Services,

9   Dental Services. I haven't found that one

10   yet, frankly.

11   (Off microphone comments)

12   MR. MCINERNEY: And who would like

13   to discuss this? Roberta or Chisara? Robert,

14   I mean.

15   MS. ARAVAMUDHAN: Just a very

16   quick overview. This is a basic health

17   services measure in terms of simply seeing,

18   you know, the utilization with the program, so

19   any dental service just simply gets captured.

20   The denominator is anyone enrolled in the

21   program.

22   And so this is the type of measure

1   that we were talking about in terms of, you

2   know, capturing that access issue that we

3   mentioned with the other measures.

4   The one unique thing about this

5   measure that is not there with any of the

6   other six measure is that it does compete with

7   a currently endorsed measure, so we would be

8   happy to answer any questions as to why we

9   developed this measure knowing that there is

10   a currently endorsed NQF measure when we come

11   to that criteria.

12   MR. VALDEZ: Okay, here we go

13   again. The title to the measure is

14   Utilization of Services, Dental Services, and

15   I'll just point out that the people raised

16   some concerns about the title of the measure

17   since this is a measure not in general of

18   dental services but focused on children. So

19   that should just be noted.

20   With regard to evidence, the

21   developers presented a series of arguments

22   about access to care and access to care being

1   the gateway to really understanding quality of

2   care and program performance.

3   What else came up during that

4   discussion? The only other thing that came up

5   during the discussion was the fact that this

6   is a gateway measure to any kind of health

7   services research activity.

8   MS. SAMPSEL: Chisara, did you

9   have anything? We had started 2511 while you

10   were out of the room and now chewing

11   something, so it seems appropriate to ask if

12   you had anything to add.

13   MS. ASOMUGHA: For the evidence

14   section alone?

15   MS. SAMPSEL: We're at just the

16   very beginning of this one.

17   MS. ASOMUGHA: No, nothing else to

18   add.

19   MR. MCINERNEY: Any other

20   discussion? Okay, Kaitlynn, let's do the

21   first vote on evidence, please.

22   MS. ROBINSON-ECTOR: 1a, evidence,

1   structure, process, intermediate outcome. 1

2   is high, 2 is moderate, 3 is low, 4 is

3   insufficient evidence, 5 is insufficient

4   evidence with exception. And you can start

5   voting now.

6   We are just waiting on one more

7   vote. Oh, okay, sorry. All the votes are in.

8   Evidence, there were nine votes for high,

9   moderate there were nine votes, for low there

10   was one vote, and for insufficient evidence

11   there was one vote.

12   MR. VALDEZ: The next section is

13   opportunity for improvement. The developers

14   presented information about differential

15   access to services, oral health services,

16   dental services in particular through a

17   variety of studies in the literature. The

18   workgroup rated it moderate, moderate-high.

19   MR. MCINERNEY: Any discussion on

20   this measure? Okay, Kaitlynn. Thank you.

21   MS. ROBINSON-ECTOR: For

22   performance gap, 1 is high, 2 is moderate, 3

1   is low, and 4 is insufficient, and you can

2   start voting.

3   We have all the votes and voting

4   is closed. For performance gap there were 18

5   votes for high, two votes for moderate, zero

6   votes for low, and zero votes for

7   insufficient.

8   MR. VALDEZ: Priority. With

9   regard to priority, the developers presented

10   information on utilization barriers, which

11   seemed to be pretty low, utilization, that is.

12   The workgroup discussed the issue

13   and really identified and said while this

14   measure is not really a measure of quality, it

15   is really the gateway to assessing quality,

16   understanding whether or not any one of these

17   children receive services are not. It's a

18   signal certainly to payors and others whether

19   the issue is a serious issue for concern or

20   not.

21   MR. MCINERNEY: Any further

22   discussion on priority? Okay, Kaitlynn,

1 please.

2 MS. ROBINSON-ECTOR: For higher

3 priority, 1 is high, 2 is moderate, 3 is low,

4 and 4 is insufficient, and voting is open.

5 Okay, all the votes are in and voting is now

6 closed.

7 There were 16 votes for high, four

8 votes for moderate, zero votes for low, and

9 zero votes for insufficient.

10 MR. VALDEZ: The next section is

11 reliability. Certainly defining the numerator

12 was fairly easy. The question is whether a

13 child received any services on the dental

14 side, and the denominator was the population

15 enrolled in the health plan or program. The

16 reliability testing met the standards that the

17 working group found acceptable.

18 MR. MCINERNEY: Further comments

19 on the reliability? Okay, Kaitlynn, please.

20 MS. ROBINSON-ECTOR: For

21 reliability, 1 is high, 2 is moderate, 3 is

22 low, and 4 is insufficient, and voting is now

1   open. And we're still waiting for one vote.

2   All of the votes are now in and

3   voting is closed. For reliability, there were

4   12 votes for high, seven votes for moderate,

5   one vote for low, and zero votes for

6   insufficient.

7   MR. VALDEZ: With regard to

8   validity, the working group raised the same

9   questions that we raised earlier, having to do

10   with the splitting off of use of oral health

11   or dental services focused on who the provider

12   was rather than whether the child or children

13   in the program received the services.

14   This is the same issue we've

15   talked about and the developers have said they

16   have parallel measures and sort of either/or

17   measures as well that we've learned about

18   today.

19   There were some other questions

20   about the validity. Let's see. There was

21   some questions about whether the service was

22   needed or not and whether that should be taken

1   into account in looking at whether children

2   receive services, given that we're looking at

3   children of all ages and any service.

4   MR. MCINERNEY: Any further

5   discussion on validity? Okay, we'll vote

6   please.

7   MS. ROBINSON-ECTOR: For validity,

8   1 is high, 2 is moderate, 3 is low, 4 is

9   insufficient, and voting is open.

10   All votes are in and voting is now

11   closed. For validity, there were six votes

12   for high, 12 votes for moderate, two votes for

13   low, and zero votes for insufficient.

14   MR. VALDEZ: With regard to

15   feasibility, the same data sources we've been

16   looking at today were used for this particular

17   measure across several Medicaid and CHIP

18   programs in two states and a commercial plan.

19   No other questions were raised

20   other than those about using administrative

21   claims for these kinds of activities in

22   populations.

1   MR. MCINERNEY: Thank you. Any

2   further discussion on feasibility? All right,

3   let's vote.

4   MS. ROBINSON-ECTOR: For

5   feasibility, 1 is high, 2 is moderate, 3 is

6   low, and 4 is insufficient, and voting is now

7   open. And we're waiting for one more vote.

8   Okay, all the votes are in and

9   voting is now closed. For feasibility, there

10   were 16 votes for high, four votes for

11   moderate, zero votes for low, and zero votes

12   for insufficient.

13   MR. VALDEZ: With regard to use,

14   the current measure is currently being used in

15   two states and two programs. No, it's being

16   used in Texas, CHIP and Medicaid, and also

17   being used by CMS. It's clearly an indicator

18   of access to care that people considered

19   fundamental.

20   MR. MCINERNEY: Any further

21   discussion on usability? Whoa. All right,

22   let's vote please.

1   MS. ROBINSON-ECTOR: For usability

2   and use, 1 is high, 2 is moderate, 3 is low,

3   and 4 is insufficient information. Voting is

4   now open.

5   And we're still waiting for two

6   more responses. All of the votes are in and

7   voting is now closed. For usability and use,

8   we have 14 votes for high, six votes for

9   moderate, zero votes for low, and zero votes

10   for insufficient information.

11   MR. MCINERNEY: Okay, we're now

12   ready to vote on whether to adopt this

13   measure, or endorse this measure I should say.

14   Any last minute comments before we vote on the

15   suitability for endorsement? Oh, this is

16   really good. All right, let's vote.

17   MS. ROBINSON-ECTOR: For overall

18   suitability for endorsement, 1 is yes and 2 is

19   no. Voting is open.

20   And we're still waiting for two

21   more responses. All votes are in and voting

22   is now closed. For overall suitability for

1   endorsement, Measure 2511, Utilization of

2   Services, Dental Services had 19 votes for yes

3   and one vote for no. The measure passes.

4   MR. MCINERNEY: Thank you,

5   everyone. I think we're hitting our stride

6   here. Okay, the next measure for --

7   MS. SAMPSEL: Actually, Tom, we're

8   going to take a break. We're seeing a lot of

9   people walk around, so kind of an indication

10   folks might need a break.

11   MR. MCINERNEY: Okay. It's 2:10,

12   take a what, ten-minute break. Get back at

13   2:20, please.

14   (Whereupon, the foregoing matter

15   went off the record at 2:10 p.m. and went back

16   on the record at 2:19 p.m.)

17   MR. MCINERNEY: 2517, Page 74 in

18   the workbook. The measure title is Oral

19   Evaluation Dental Services.

20   And the description, brief

21   description of the measure is percentage of

22   enrolled under children under 21 years who

1   received a comprehensive or periodic oral

2   evaluation within the reporting year. Would

3   the measure developer like to say anything

4   about this one?

5   MS. ARAVAMUDHAN: Just that,

6   again, it's based on the same data sources, so

7   no complications here in terms of risk or

8   anything. But the evidence is weak and we

9   recognize that.

10   And like I, like we said at the

11   beginning of the session this morning, this is

12   based on the, this is evidence and form. So

13   what is available and what the dental

14   community feels is required in terms or

15   establishing a dental home.

16   The oral evaluation is simply the

17   procedure that's used as a marker to see

18   whether kids are actually in the dental home.

19   MR. CRALL: And I think the only

20   thing I would add is that this is, I think, an

21   effort on our part to sort of push the

22   envelope just a bit. There's certainly, at

1   the last measure that you approved, looks at

2   whether a child gets any services.

3   And, you know, clearly that can

4   span the entire gambit, it really doesn't give

5   us a good indicator of whether or not that

6   service was for an emergency visit. There are

7   other sort of measures that look at the full

8   gamut of diagnostic procedures where, again,

9   if a child gets one radiograph that counts.

10   In this case we really are looking

11   for something, putting forward something that

12   we believe is more of a indicator of a dental

13   home or a regular and ongoing use of services.

14   And inherent in the use of the codes for this

15   measure is the development of a treatment

16   plan.

17   So this at least, those two codes

18   basically say, all right, this child got a

19   full assessment of their oral health status

20   and the treatment plan was developed. That's

21   what's inherent in the use of the code.

22   And so to us that's a marker that,

1   okay, someone is actually, this child is

2   really entering the sort of mainstream of oral

3   healthcare not on some episodic or sporadic

4   basis.

5   There are limitations both in

6   terms of, you know, one measured in the data.

7   And there, as Christian indicated, we know in

8   terms of the evidence. But that's the context

9   in which we're trying to use this measure

10   along with the other measures.

11   MR. MCINERNEY: Thank you. Renee

12   or Ron, who, which of you wants to lead the

13   discussion? Oh, David, did you?

14   MR. KROL: Just to, I think you

15   answered, Jim, I just wanted to make sure I

16   understand it correctly.

17   So this measure is essentially a

18   subset of the previous measure? This is a

19   more specific, this is one of the many

20   potential services that could have been

21   utilized in the previous measure, is that

22   right? Okay.

1   And then I guess I'll hear this

2   from Ron or Renee, is the evidence that goes

3   from the measure, or the measure to the

4   outcome, that connects the measure to the

5   outcome?

6   I would assume that in the review,

7   in the previous one there was some evidence

8   that showed any service received lead to a

9   healthier, lead to an outcome. And then now

10   we'll hear that just having the oral health

11   evaluation, the oral evaluation actually is

12   connected to an outcome, right?

13   That's what we would expect to

14   see. We would expect to see evidence that in

15   the previous one, and I guess I should have

16   asked this previously because it's going to

17   come up in the continuity, my review of

18   continuity, that any dental service will lead

19   to a, presumably, an improved health outcome.

20   And the evidence shows that.

21   And then in this one, specifically

22   evidence shows that an oral health, that just

1   having an oral health evaluation with the

2   treatment, all that's tied to that, including

3   the treatment plan, actually leads to a health

4   outcome.

5   And I ask that question because

6   it's, and I didn't, I apologize that I didn't

7   read probably as deeply into this one as I

8   should have. But my limited knowledge of the

9   evidence is that for instance, fluoride

10   varnish, it's very clear you apply fluoride

11   varnish there's going to be a pretty clear

12   difference or improvement in health outcome.

13   You apply a sealant there's going to be a very

14   clear difference in health outcome.

15   But essentially just in the last

16   one, just walking in the door of the dentist's

17   office actually has a connection to an

18   improved health outcome. I'm assuming that in

19   that one there was evidence and now in this

20   one, just having, just the fact that a dentist

21   did an oral health evaluation actually has an

22   improved, leads to an improved health outcome

1   I think will be very important to see.

2   MR. INGE: Can I comment? Because

3   I actually saw them both very differently.

4   MR. MCINERNEY: Okay.

5   MR. INGE: I see these as process

6   measures and that they do not lead to a

7   specific health outcome or improvement. It's

8   that they are the foundation that enters

9   someone into the system.

10   Access being, I guess you could

11 call it access and outcome, having access to

12 the service is what they actually define.

13 That a patient had an opportunity to access

14 the system.

15   It doesn't define whether or not

16 what occurred and whether or not what occurred

17 moved in a positive direction. It's merely a

18 measure of the ability of, if we're at a plan

19 level, the plan to provide access to

20 healthcare services.

21   That's how I interpret it. I'm

22 not, and developers, please comment. Please.

1   MS. ARAVAMUDHAN: And that's

2   exactly what our thought process was. And

3   we'd like to take you back to our kind of

4   framework where you have to follow the patient

5   through the deliver system.

6   And first one is linked to care

7   and then diagnosed and then prevent and then

8   treatment and then healthy. So this sort of

9   address that link to care and the diagnosed

10   component.

11   And so if you know that a child

12   actually has been evaluated and the treatment

13   plan generated, that's the first step. And

14   then next you would want to do, okay, was the

15   treatment plan rendered and completed and is

16   the patient health?

17   So again, it's not a simple

18   measure that can be used on its own, it's part

19   of the bigger picture.

20   MR. INGE: So it would be helpful

21   to learn from the NQF folks, if it exists, and

22   I didn't see one as far as continuity expect

1   for melanoma for NQF, whether, for instance,

2   NQF has shown that a visit to a physician, as

3   a process measure, or a annual physical exam

4   for example, as a process measure actually has

5   been shown and endorsed by NQF as a leading,

6   as a quality measure?

7   Because I, there is maybe not a

8   one-to-one correlation between the two,

9   they're not equivalent necessarily, but it is,

10   I guess this question, just walking into the

11   door of the physicians office lead to a health

12   outcome?

13   And maybe I'm not making sense but

14   I'm just struggling with, I'm struggling with

15   that connection between the measure and the

16   outcome. I know that it's a process measure

17   but --

18   MS. ARAVAMUDHAN: Right.

19   MR. INGE: -- I don't know what

20   NQF has found in other settings. And when I

21   looked, I'm getting ahead of myself here I

22   apologize.

1   But when I looked for the terms

2   continuity in NQF's measures, there's nothing

3   that, for instance, that really except for

4   melanoma, and that's really just a data base

5   not necessarily the fact that you've actually

6   had continuity in melanoma care, that there's

7   any quality measures endorsed by NQF.

8   MS. MUNTHALI: That's actually a

9   very good question and it's one that

10   committees struggle with constantly throughout

11   our projects. And what we often remind

12   committees about is that the outcome, you want

13   the process to be proximal to the outcome.

14   And it really should be based in

15   evidence. And so there should be evidence to

16   support, whatever process it is would lead to

17   this outcome. Whether, you know, positive or

18   negative.

19   And so I would, this is a good

20   discussion for the Committee to have. Knowing

21   that this measure is also part of one that

22   seems a little more comprehensive, that's

1 another discussion topic for the Committee to

2 have, so I will just leave it there and if

3 there are other questions.

4   MR. MCINERNEY: Well Mark Twain, a

5 long time ago said, you know, if one visits a

6 physician, one stands about a 50-50 chance of

7 benefitting from the encounter. And some

8 people think that may still be true today.

9   But in seriousness, if I remember

10 correctly, there are some HEDIS measures. And

11 for children at least so many visits in the

12 first year of life to a physician and so many

13 in the second --

14   MR. KROL: Yes.

15   MR. MCINERNEY: Right?

16   MR. KROL: Yes.

17   MR. MCINERNEY: And were those NQF

18 endorsed or are they just NCQA HEDIS measures?

19   MS. MUNTHALI: We do have some

20 measures that are based on HEDIS that are

21 endorsed by NQF. Not all of them are though.

22   MR. MCINERNEY: Yes.

1   MR. BIALEK: A number of years ago

2   for the annual physical that was recommended

3   by the medical community. And ultimately the

4   evidence showed that it varied by age groups

5   and so the recommendation changed based on the

6   science.

7   In this instance I don't, I'm not

8   hearing that there's a lot of science around

9   the annual dental visit. It sounded like

10   there was some expert opinion around it which

11   sometimes can be the evidence that we want to

12   use. So that's one comment.

13   The other is that the measure

14   seems to be measuring two different things.

15   One is a comprehensive oral exam

16   and the other is a periodical oral exam. And

17   it doesn't seem appropriate for a measure to

18   have two different things that it's measuring

19   in the one measure.

20   MR. INGE: So if I could respond

21   to that. And a suggestion to the developers

22   that it should be just an oral evaluation.

1   The descriptors that you have for

2   a comprehensive and a periodic reflect back to

3   the coding that used by dentists to submit

4   those evaluations.

5   So a recommendation would be that

6   the statement would only be for a oral

7   evaluation and that would encompass all of

8   those exam codes and that would make it more

9   clear that it's an access process.

10   MR. SPANGLER: Also, Ron, you

11   could, they could both be one in the same,

12   right? You have a comprehensive periodic,

13   they don't have to be exclusionary right? Or

14   do they?

15   MR. INGE: What occurs at the exam

16   can be the same. But in regards to reporting,

17   we have CDT codes that specify the difference.

18   This is where it gets complicated.

19   So because of the administration, a

20   comprehensive exam is applied to a patient,

21   usually at their first visit to a dentist.

22   Then that patient becomes a patient of record.

1   Based upon the benefit plan

2 design, there are then periodic evaluations

3 that are allowed, and which our profession has

4 adopted themselves to that are reimbursed on

5 a regular basis. Within six months or twice

6 within a benefit period.

7   Then there are limitations on a

8 lot of plans, not so much on Medicaid, where

9 a patient who has been within a practice for

10 a extended period of time, it is assumed that

11 the doctor is managing their evaluations on a

12 regular basis and therefore a comprehensive

13 exam isn't necessary two years later, three

14 later. Because they're in continued care.

15   It's not until there is a break in

16 care of at least a year's time period that a

17 comprehensive can then come back into play.

18   MR. SPANGLER: So it's like an

19 initial visit with a new patient versus a

20 followup visit --

21   MR. INGE: Followup --

22   MR. SPANGLER: -- with an

1   established patient?

2   MR. INGE: Correct.

3   MR. SPANGLER: Okay, I got it.

4   MS. ARAVAMUDHAN: As the developer

5   we would be very willing to make that change

6   editorial. We actually started that way and

7   then people started, is this code included,

8   that code included. So we tried to make the

9   description more, but we can do that as an

10   editorial change, definitely.

11   And in terms of the evidence, if I

12   might, there is a distinct difference in the

13   evidence between children and adults. And

14   we're very cognizant of that.

15   So as we are looking at the adult

16   populations we are struggling with a measure

17   like this for the adult population. It's not

18   as straightforward.

19   But for children, because of the

20   growth and development and the guidance and

21   the habit that needs to be formed in the child

22   in terms of maintaining oral health, the

1   guidelines definitely say, given the limited

2   evidence this is how we would extrapolate it.

3   MR. MCINERNEY: For the annual?

4   MS. ARAVAMUDHAN: For the annual.

5   If you actually look at the guidelines,

6   especially the NICE guidelines for dental

7   recall, it's every, if I'm right, it's every

8   three months to at most every 12 months. So

9   we picked the 12 months, we didn't go any --

10   MR. SALIVE: So how does this

11   differ from the last one? I mean that's what

12   I don't understand.

13   I was fine with the last one as a

14   measure of access, but this one, you know, it

15   doesn't seem that different to me. I guess

16   maybe I'm just, I mean, I have conceive of,

17   you know, I guess I have that physician

18   analogy and I'm, but I'm not, I'm willing to

19   overlook that.

20   But if there's only three types of

21   visits, prevention, diagnosis or treatment

22   right? And presumably you're going to do

1   prevention in the pediatric population that's

2   why, the whole point.

3   So saying they have to have

4   diagnosis, you know, here, is that really any

5   different? I mean no one is going to just

6   have treatment, they are going to be looked at

7   for diagnosis first. So how does this really

8   differ from the last one?

9   MS. ARAVAMUDHAN: Okay, I'll start

10   first and then Dr. Crall can jump in. So we

11   had a lot of problem as we looked at the

12   previous measure and this measure.

13   And the thing is, like Dr. Crall

14   said with the previous measure, if you go to

15   the emergency room it's counted. So the true

16   measure of access is this when you can

17   actually get the child into care.

18   So the previous measure, like we

19   mentioned, is a basic health services measure

20   in terms of utilization of care. Period.

21   This one is actually saying, okay,

22   take out those emergency visits, those problem

1 focus visits that anyone else has and let's

2 talk about the child actually entering care

3 and having a dental home. So that we see as

4 a significant difference between the previous

5 measure and this measure.

6   MR. CRALL: And I don't think I

7 have a whole lot more to add to that. And

8 again, they tend to be looked at as, okay, we

9 have a rate or a count for this particular

10 measure. And then you have other, you know,

11 context to whether or not the child is

12 enrolled and did or didn't get services.

13   But this one really is, as I said,

14 an effort to move forward to say there is a

15 logical sequence and a process of care that we

16 would specify is followed. But unless we have

17 ways of measuring that we don't know to what

18 extent that's being followed or how consistent

19 that's being done across age groups, across

20 plans, across a variety of things.

21   And so this is really an effort to

22 try to put a little finer point on something

1   that is a proxy for that ongoing source of

2   care. There are other frameworks for

3   categorizing groups of procedures or services

4   beyond diagnosis, prevention and treatment, as

5   you said, in the current CMS 416 scope.

6   They just look at the measure that

7   you previously passed, that the child got any

8   service. And then jump to prevention and jump

9   to treatment have nothing in, well there's a

10   new one for all the diagnostic services. But

11   we're looking specifically for an examination

12   which is an indicator to us that that child's

13   oral health has been assessed and that

14   somebody has a plan that then we could, you

15   know, look to follow up and see what their,

16   either subsequent use of services either by

17   periodicity or by nature could be tracked back

18   to that particular marker.

19   MR. VENKATESH: So I guess I'm in

20   complete agreement with Marcel about trying to

21   understand how this is an incrementally

22   different measure with respect to the outcome

1 of access, if that's what the important thing

2 is.

3   But what concerns me more, I

4 guess, was your answer where I did not realize

5 in the previous measure that emergency

6 department visits would be constituted a form

7 of access. Because I thought the billing

8 codes that you guys had listed here are

9 nothing that I've ever billed before.

10   MR. CRALL: No, I think treatment

11 for an emergent condition by a dentist would

12 be covered. So I think, I think I did hear

13 Kristen say --

14   MR. VENKATESH: Okay.

15   MR. CRALL: -- emergency room,

16 that's because we're working on another set of

17 measures and her mind is over there probably.

18 But no, you're right, that isn't the case.

19 No.

20   MR. VENKATESH: Okay. So if

21 that's the case then it just seems to me like

22 to try to parse out something like prevention

1   separate from diagnosis, separate from

2   treatment when in reality these things happen

3   concurrently or some of the reasons why these

4   things are important, like you said, teaching

5   about oral health.

6   I can't imagine that you would not

7   discuss oral health and that type of

8   prevention and education would not occur in

9   the context of only a treatment visit that's

10   captured by the previous measure.

11   It seems odd to me that we have to

12   have another measure to just say, did you code

13   for an exam part? And so that's where I guess

14   what I'm getting at is, when we started the

15   day, one of the things Helen brought up was

16   the idea of measure parsimony. Right.

17   Having a limited number of

18   measures that are able to capture the largest

19   amount of information. And in my, what I'm

20   asking here is, by this addition of an

21   incremental measure, right, are we just

22   measuring another thing but not actually

1   getting any other meaningful information for

2   community level health improvement?

3   MR. CRALL: I think it's a

4   legitimate question and again, usual

5   processes, particularly in pediatric offices

6   I can speak to, you know, is that from an

7   efficiency standpoint, absolutely.

8   You know, bringing in a child you

9   basically do the assessment, you develop the

10   treatment plan, you do the preventive services

11   and try to do that all at once because it

12   avoids, you know, and it starts you, if

13   there's any additional treatment that's

14   necessary, it starts you and puts you into a

15   different phase.

16   But again, we can't, if we could

17   make assumptions we wouldn't need measures.

18   So it really does help us to understand the

19   extent to which that child's oral health is

20   being assessed on some periodicity.

21   And treatment plans can get very

22   prolonged. You can have programs where

1   preventative services actually might be

2   provided and not necessarily combined with an

3   examination.

4   We feel because of the importance

5   of the ongoing source of care, which I know

6   we're going to get to in the next measure, and

7   the fact that there is that process of care,

8   that there is an addition to that.

9   And I can only add from a

10 historical standpoint, I chaired an expert

11 panel for NCQA and this is back in the late

12 '90's, this is one of the recommendations that

13 that group made for an additional measure as

14 well. But that's just historic.

15   MR. BAER: From a Medicaid

16 standpoint I agree with this measure because

17 we do have something called a Special Needs

18 Unit and we get calls everyday to make special

19 arraignments to get people care. And we'll

20 get a lot of calls with urgent needs.

21   And those are the ones that we

22 see, you know. They may do us a special

1   favor, but are they going to keep that child

2   long term?

3   So, you know, if that child can

4   stay with that plan long enough to get a

5   comprehensive exam and not a reactive

6   evaluation due to a painful tooth, abscess,

7   you know, whatever, I do feel that that's how

8   I see this from a Medicaid standpoint. It

9   would be helpful for me to see this data.

10   MR. INGE: And actually I was

11   going to repeat the same thing. This

12   eliminates those episodic incidences because

13   unfortunately in dentistry a majority of the

14   care is delivered by general dentists. And it

15   usually, not usually, quite often it's

16   episodic.

17   And it's just getting the patient

18   out of pain. It isn't actually putting them

19   on a path for a better health outcome. By

20   doing an evaluation you at least put them on

21   the path for a better health outcome.

22   MR. MCINERNEY: Now, move into

1   evidence.

2   MR. BAER: Okay. So the evidence,

3   based upon the data sets that we've been

4   talking about all morning, being able to

5   capture this information on a claims database,

6   there are specific codes.

7   And as I recommended that we just

8   refer to the oral evaluations, which will

9   cover all of those exam codes, and be able to

10 identify when a patient has been seen in an

11 office to begin a pathway to better

12 healthcare.

13   Unless there are any other

14 challenges or questions about the dataset?

15   MR. MCINERNEY: Are we ready, oh,

16 here we go, Eric.

17   MR. FRANCE: So it seems like this

18 question is about tracking the recommended

19 interval that children should be seen every

20 year from ages 1 through 21. And I know in

21 the evidence package it refers to that

22 Cochrane review.

1   Only one randomized trial and they

2   say there's very low quality evidence to know

3   what the right interval is. So from the

4   evidence quality review about what the right

5   interval is, this is saying we don't really

6   know.

7   And as a pediatrician I'm often

8   looking at the HEDIS NCQA about how often

9   should children come in for a visit. And I

10   look at that and say, wow, that's, you know,

11   it's good that they get their shots, they get

12   their developmental screening but the actual

13   need for the visit itself, is that truly an

14   evidence-based intervention?

15   And that's where I can get stuck

16   and say I don't need to pay much attention to

17   that metric because I don't know what the

18   strong evidence is behind it.

19   So this feels similar in the sense

20   that what the right periodicity is for the

21   visit for a child between age 1 and age 21

22   that therefore provides good prevention of

1 caries is not strong.

2   MS. ARAVAMUDHAN: And I like I

3 said, like we said this morning, this is a

4 situation where it's evidence informed, not

5 really, you know, evidence based because you

6 don't have that strong evidence to support it.

7   I actually picked up the words

8 evidence informed from the Bright Futures

9 guidelines where, you know, sometimes you kind

10 of have the same problems in terms of your

11 periodicity schedules. The variety of the

12 screenings that are recommended in the Bright

13 Futures, this is really that parallel in

14 dentistry.

15   MR. MCINERNEY: So if there's no

16 further discussion on evidence, shall we vote

17 on that please.

18   MS. ROBINSON-ECTOR: For evidence

19 1 is high, 2 is moderate, 3 is low, 4 is

20 insufficient evidence and 5 is insufficient

21 evidence with exception. Voting is open.

22   So we now have all of our votes

1   and voting is now closed.

2   MS. MUNTHALI: So we haven't

3   reached consensus, it looks like a split vote.

4   Am I counting this right, is it 1 high, 9

5   moderate? And I can't read, I'm sorry, below

6   --

7   MS. ROBINSON-ECTOR: It's 5 below.

8   MS. MUNTHALI: -- 5 below.

9   MS. ROBINSON-ECTOR: 4, yes.

10   MS. MUNTHALI: It's 10 and 10, so

11   what, we are missing one vote so let's re-

12   vote. Sorry, about that, I think we're back

13   to 21 in the room.

14   MS. ROBINSON-ECTOR: Okay, so

15   voting is now open. We're waiting on one

16   vote. Okay, all the votes are in and voting

17   is now closed. Okay, there were 10 votes.

18   (Off record comments.)

19   MS. ROBINSON-ECTOR: Okay, sorry

20   about that I think we're going to have to re-

21   vote again.

22   (Off record comments.)

1   MS. ROBINSON-ECTOR: Okay, sorry.

2 So there are 10 for moderate, 6 votes for low,

3 4 votes for insufficient and 1 vote for

4 insufficient evidence with exception.

5   MS. MUNTHALI: So based on the

6 Committee's voting, this measure will not go

7 forward. It has failed on evidence for

8 importance to measure and report. So, sorry.

9   MR. KROL: Remind me what

10 insufficient evidence with exception means?

11   MS. MUNTHALI: So I will point you

12 to your algorithms. If you go to the back

13 page of the first page, which would be page,

14 well I guess it's 9, it's not in the back it's

15 the second page.

16   So if you, to answer this. If you

17 had said on Number 7, is empirical evidence

18 submitted but without systematic review and

19 grading of the evidence, if you answered no

20 you go to 10. Are there or should there be

21 performance measures of related health outcome

22 or evidence based intermediate clinical

1   outcomes of process?

2   This is what I was talking about

3   before. If you had said no to that you'd go

4   over again to Number 11, is there evidence for

5   systematic assessment of expert opinion that

6   the benefits of what is being measured

7   outweighs potential harms.

8   And then the Committee would make

9   a decision on whether or not you agree it's

10   okay to hold providers accountable for

11   performance in the absence of empirical

12   evidence, as you were talking about before, of

13   benefits to patient.

14   If that is the case you would rate

15   it as insufficient evidence with exception.

16   MR. KROL: So that falls in the

17   negative camp rather then positive camp? I

18   guess that's my question.

19   FEMALE PARTICIPANT: No, it will

20   move forward.

21   MR. KROL: So then it's 11, but we

22   have to have 60 percent?

1   MS. MUNTHALI: Yes.

2   MR. KROL: Oh, I see what you're

3   saying.

4   MS. MUNTHALI: Yes, sorry.

5   MR. KROL: You don't have to have

6   more then 50 percent.

7   MS. MUNTHALI: Sorry, I should

8   have explained that.

9   MR. KROL: I get it.

10   MS. MUNTHALI: So yes. But that

11   is a positive, that's, you're making --

12   MR. KROL: Okay.

13   MS. MUNTHALI: -- an exception to

14   the rule. So, I mean besides the conversation

15   there was a lot of rich discussion before but,

16   so that we can note it for, not just us but

17   for the developers, is there anything else

18   you'd like to say about your vote? Either

19   way, if you voted for it or against, we'd like

20   to make note of that.

21   MR. BAER: I'm going to make a

22   comment. I think without this measure it

1 makes the previous measure almost irrelevant.

2 To me. Just my opinion.

3   MR. MCINERNEY: Thank you. So

4 noted.

5   MR. VENKATESH: I would only kind

6 of encourage the developers to think about, if

7 you read about this measure or bring it

8 forward again, how you interpret it vis a vis

9 the first measure. You can imagine a world

10 where both of these measures are endorsed and

11 they're both being used.

12   And I can understand from

13 Michael's perspective how that can be useful.

14 But if you think about it, if the scores for

15 both measures go up we all feel good that

16 access is getting better. If the scores for

17 both measures go down we all feel bad because

18 access is getting worse.

19   But the more likely thing that can

20 happen, because the visitations are different

21 between the two, is that the measure, first

22 one, could go down, while the second one goes

1   up potentially because you're having better

2   preventative visits and reduced --

3   MR. CRALL: I actually think the

4   other scenario is probably more likely and

5   would tell you whether or not you actually

6   have people, you know, that are basically

7   getting care for episodic sort of things that

8   somebody has to arrange for versus not. So I

9   don't necessarily agree that that's the more

10   likely scenario at all.

11   MR. VENKATESH: I just think that

12   you should have some analysis that show the

13   incremental of what, who's getting captured or

14   not captured between the two.

15   MS. LUCK: I'm wondering, for a

16   possible re-submission in the future, if given

17   the fact that there's only this one, the

18   Cochrane study that cites one randomized

19   controlled trial which didn't clearly show an

20   impact, whether you might not be advised to

21   really explicitly look for a rate as

22   insufficient evidence with exception in the

1 measure form.

2   Saying that, because as you read

3 through the algorithm, Lisa, I thought okay,

4 so the experts, we don't have evidence but

5 what is it here, the final one, is there

6 evidence of a systematic assessment of expert

7 opinion, kind of work that angle in order to

8 get Committee approval.

9   MR. KROL: She means on re-

10 submission. She's suggesting --

11   MS. ARAVAMUDHAN: No, but we don't

12 have the ability to take that on the

13 submission form, it's your judgement. I think

14 we give you whatever we have.

15   MS. MUNTHALI: But I think what

16 she's saying is to make sure that you provide

17 the information. I think if you had

18 additional information on the submission form

19 that could speak to that.

20   MS. LUCK: And following the

21 algorithm step by step, if a systematic review

22 is provided then your pushed into the rating

1   it as low, moderate or high. Whereas if the

2   systematic review is not provided, you could

3   maybe mention it and say that we don't want to

4   officially submit this as evidence --

5   MR. CRALL: Right.

6   MS. LUCK: -- because we accept

7   that it's not enough. However, the expert --

8   MR. CRALL: Right, the guidelines

9   suggest that every six months or, you know, at

10   the discretion based on risk. I mean that's

11   what we have as guidelines that are synthesis

12   of that but don't reach the level of

13   systemized, randomized, control trial. Yes.

14   MS. SAMPSEL: Okay, any other

15   comments?

16   MS. KHAN: Sorry, just a quick

17   process check. We've developed a new

18   consensus process, so basically any measure

19   that falls within the 40 to 60 range is going

20   to keep going forward.

21   With noting that what your scores

22   were because if you think about, it's 10

1 moderate and 1 voting, one saying it's okay

2 with an exception, so it's really 11. And

3 then it's 4 said insufficient information and

4 6 said low. So it's a vote 11 to ten.

5   So we're going to keep going

6 forward with the voting on the measure. It

7 will go out for public comment. There'll be

8 no overall vote, but we are going to send it

9 out for public comment.

10   And then once the Committee is

11 able to reconcile all the comments that's when

12 we'll come up with the final vote. Does that

13 sound good to everybody?

14   MR. KROL: I can't help but feel

15 like that some of this may be the challenge of

16 a large part of this room being very familiar

17 with medical related work and medical coding

18 versus dental and dental coding.

19   And I just, what I sense, and that

20 maybe completely wrong, but what I sense here

21 is that a potential analogy for the challenge

22 we're having here is for those pediatricians

1 in the room, the question of quality access to

2 care being defined as children, a child say 1

3 to 4 having a 99392 code, if you know what I'm

4 saying there, so that's the, that's our

5 periodic comprehensive evaluation. That's our

6 equivalent.

7   Versus a whole series of 99213s.

8 Which are just, you know, a problem. I'm

9 addressing a problem all year long.

10   And that I think is, so that I

11 think, in speaking that language of the

12 physicians, it's, is the first measure that we

13 addressed was the 99392s plus all the 99213s

14 thrown together in one year versus this, just

15 pulling out the 99392. The periodic.

16   And whether there's a question of

17 is, is that actually truly better access to

18 care or what children should be providing,

19 being provided versus say a series of, put out

20 the fire, put out the fire, put out the fire

21 all year long.

22   I don't know if that helps this

1   conversation but, because I sort of live in

2   this world straddling medicine in dentistry,

3   I think I see that there may be a little bit

4   of a challenge here for us on the medical side

5   understanding this.

6   I don't know if that helps or

7   changes, I'm not trying to persuade anyone

8   from changing anything but I just think there

9   maybe, this may be a larger issue or just the

10 challenge that we're facing here. So I'll

11 contribute that.

12   MR. MCINERNEY: So we should

13 continue to vote on the different, the next

14 measures since we've decided that the rules

15 allow us to do that.

16   So the next would then be the

17 scientific, the opportunity for improvement.

18 Would you like to talk to that, Ron, please?

19   MR. INGE: So the opportunity for

20 improvement again refers to the two systems

21 where it's currently being measured and the

22 opportunity that it is readily available in

1   both delivery systems, medicaid and commercial

2   environment. And a measure of potentially

3   access provided by a plan.

4   MR. MCINERNEY: Any discussion on

5   that? Okay, let's vote then on the

6   performance gap or opportunity for improvement

7   please.

8   MS. ROBINSON-ECTOR: For

9   performance gap, 1 is high, 2 is moderate, 3

10   is low and 4 is insufficient. Voting is now

11   open. All of the votes are in and voting is

12   now closed.

13   For performance gap there were 8

14   votes for high, 10 votes for moderate, 1 vote

15   for low and 2 votes for insufficient.

16   MR. INGE: So the next is

17   priority. And as was mentioned by the

18   developers, the priority is to be able to

19   evaluate children being introduced into a

20   healthcare path as opposed to episodic care

21   which would just simply be problem solving.

22   And then the introduction into a

1   path towards better healthcare is a path

2   towards quality measurement so that it follows

3   along line of the placement of fluoride, which

4   we've discussed earlier we well as the

5   placement of sealants.

6   MR. MCINERNEY: Any comments on

7   this measure? Okay. Let's vote on priority,

8   please.

9   MS. ROBINSON-ECTOR: For high

10   priority, 1 is high, 2 is moderate, 3 is low

11   and 4 is insufficient. And voting is now

12   open.

13   And we're waiting for one more

14   vote.

15   All of the votes are in and voting

16   is now closed. For high priority there were

17   5 votes for high, 11 votes for moderate, 4

18   votes for low and 1 vote for insufficient.

19   MR. INGE: The next one's

20   reliability. The methodology suggested by the

21   developers is very specific and repeatable and

22   so the reliability would be high in regards to

1   identifying the parameters or the specific

2   codes that apply to this measure.

3   MR. MCINERNEY: Any comments on

4   reliability? Okay. Let's vote on reliability

5   please. Thanks.

6   MS. ROBINSON-ECTOR: For

7   reliability, 1 is high, 2 is moderate, 3 is

8   low and 4 is insufficient. And voting is now

9   open.

10   All votes are in and voting is now

11   closed. For reliability, there are 6 votes

12   for high, 12 votes for moderate, 3 votes for

13   low and 0 votes for insufficient.

14   MR. INGE: Okay. Under validity

15   we raised the challenges of the previous

16   measure, whether or not this is a subset of

17   that measure and does it have evidence to

18   support its efficacy. So that is a challenge

19   that we've just discussed. And under validity

20   that would be the only challenge that I would

21   see.

22   MR. MCINERNEY: Any further

1   discussion on validity? Okay. Let's vote

2   please.

3   MS. ROBINSON-ECTOR: For validity,

4   1 is high, 2 is moderate, 3 is low and 4 is

5   insufficient. Voting is now open.

6   Okay, and we're still waiting on

7   one vote. All votes are in and voting is now

8   closed. For validity there is 1 vote for

9   high, 12 votes for moderate, 8 votes for low

10   and 0 votes for insufficient.

11   MR. INGE: Okay. On feasibility

12   the data source being measured is very

13   consistent, being measured through claims

14   data. Again, a very reliable source in

15   regards to the reporting of these specific

16   codes and being able to capture that

17   information. From that standpoint feasibility

18   would be fairly straightforward.

19   MR. MCINERNEY: Further discussion

20   on feasibility? Okay. Let's vote please.

21   MS. ROBINSON-ECTOR: For

22   feasibility, 1 is high, 2 is moderate, 3 is

1   low and 4 is insufficient. And voting is now

2   open.

3   All of the votes are in and voting

4   is now closed. For feasibility there were 17

5   votes for high, 4 votes for moderate, 0 votes

6   for low and 0 votes for insufficient.

7   MR. MCINERNEY: Feasibility.

8   MR. INGE: Usability. Currently

9   it's in use in two programs that the

10   developers mentioned. It is reportable to the

11   public. Is an indication or measure that can

12   be used on a plan level, programmatic level,

13   to show improvement over time.

14   MR. MCINERNEY: Thank you. Any

15   further comments on usability? Seeing none

16   let's vote please.

17   MS. ROBINSON-ECTOR: For usability

18   1 is high, 2 is moderate, 3 is low and 4 is

19   insufficient information. Voting is now open.

20   Okay, and we're still waiting on

21   one vote. Okay. All the votes are in and

22   voting is now closed. For usability there

1 were 7 votes for high, 8 votes for moderate,

2 5 votes for low and 1 vote for insufficient

3 information.

4   MR. MCINERNEY: All right, thank

5 you. So to vote on this measure overall for

6 endorsement we're in somewhat limbo territory

7 here I think. Because of the first vote being

8 an 11 to 10 votes we did not achieve a 60

9 percent majority. I'll leave it up to the

10 Committee whether we want to vote for overall

11 suitability for endorsement if that's

12 permissible.

13   MS. KHAN: The other option would

14 be to wait until public and member comment and

15 then do a vote.

16   MS. MUNTHALI: The other thing I

17 just want to add, since usability and use was

18 voted so lowly we would want to get some input

19 from you as well on that.

20   MR. MCINERNEY: Yes, Eric.

21   MR. FRANCE: I would just hesitate

22 to vote, it could make things more confusing

1 in some ways. It's like doing a test without

2 needing it.

3   MS. FRAZIER: Yes, I guess I got

4 confused in the process. Because I think it

5 seemed that if you don't vote for number one,

6 which we didn't have consensus, it really

7 marginalizes all the other votes. So I can't

8 imagine voting for an overall if we've

9 marginalized everything else. I mean, I would

10 be, I would feel very uncomfortable. It just

11 seemed to be so inconsistent.

12   It just marginalizes this specific

13 process and what we did for just this measure,

14 I think we just kind of marginalize it a

15 little bit. Especially if we vote at the end.

16 Just for this measure. I'm not sure why we

17 did that, but --

18   MS. KHAN: I do want to note also

19 that we were in the sort of 40 to 60 gray zone

20 with validity as well. So it wasn't just

21 evidence, it was also validity. So we did it

22 twice.

1   MS. FRAZIER: Well that means I

2   definitely don't want to vote for the last

3   one. I mean you just validated what, I don't,

4   think we shouldn't vote for the last.

5   MR. VENKATESH: I would also say

6   that earlier, just a few minutes ago, we said

7   we would not vote at the end. And so there

8   are things I wrote down to give as feedback to

9   the developers that otherwise would have been

10   part of maybe a discussion in the interim.

11   And so if we're really going to

12   change course to vote, when we said we weren't

13   going to at the end, that to me seems somewhat

14   drastic when we have another option which is

15   to get more information, wait until the

16   comment period's over.

17   MR. BAER: I'll make that a

18   motion, that we delay.

19   MR. BIALEK: Second.

20   MR. MCINERNEY: Hearing no further

21   discussion on delaying the vote, all in favor

22   of delaying the vote -- Do we need to use the

1   clickers or can we just do a hand --

2   MS. KHAN: We can just do hands.

3   MR. MCINERNEY: Hand vote. All in

4   favor of delaying the vote, aye. And, all

5   right, clear majority to --

6   MS. KHAN: We can hear anyone's

7   feedback at this point if you wanted to

8   provide your feedback to the developers.

9   MR. VENKATESH: We can do it

10   offline. It'll save time.

11   MR. MCINERNEY: Sorry. The next

12   one is 2518, Care Continuity Dental Service.

13   This is a continuity measure. Percentage of

14   enrolled children age 2 to 21 years enrolled

15   in two consecutive years who received a

16   comprehensive or periodic oral evaluation in

17   both years. Measure developers want to say

18   something about this one please?

19   FEMALE PARTICIPANT: This is just

20   taking, unfortunately, the previous measure a

21   step further and looking for services over two

22   years. Again, it's continuity in terms of

1   keeping the children in the dental home and

2   making sure that they're receiving the

3   services over two years.

4   MR. CRALL: Guess the only thing

5   I'd add is, you know, it is a different

6   measure and the data we have suggests that

7   it's not as close as overlap as the previous

8   measure would have been to the use of services

9   measure. So that issue about the longer time

10   period for the assessment of performance on

11   the measure, I think, makes it a different

12   measure. It's not just sort of more of the

13   same.

14   MR. MCINERNEY: David.

15   MR. KROL: Sure. So this measure

16   is a process measure that focused on whether

17   a child received a comprehensive or periodic

18   oral evaluation in each of two consecutive

19   years.

20   The connection between the process

21   and health outcome is stated in the following

22   way, "Clinical oral evaluations play an

1 essential role in caries identification,

2 prevention and treatment thereby promoting

3 improved oral health, overall health and

4 quality of life."

5   Two clinical practice guidelines

6 are presented as evidence to support the

7 measure. One from UK NICE and the American

8 Academy of Pediatric Dentistry. One of the

9 two, the UK one, comments on the frequency

10 interval of the evaluations shortest being

11 three, longest being 12, while the AAPD

12 guideline gives the average interval but does

13 not recommend an interval.

14   Limited evidence is provided to

15 show the process contribution to a health

16 outcome. The AAPD guideline states, "Early

17 detection and management of oral conditions

18 can improve a child's oral health." And

19 that's my emphasis, can, not theirs. But it's

20 interesting that that word may have been

21 purposefully used since the evidence isn't

22 necessarily there.

1   And the grades of D or GPP of the

2   evidence are provided by the UK NICE review

3   but not by the AAPD review. There's no

4   grading of the quality or definition of the

5   grading of the quoted evidence provided for

6   either of the systematic reviews.

7   The UK review, however, states

8   that there is a lack of high quality evidence

9   across studies, though that may not reflect

10   importance and professional agreement exists

11   around at least yearly intervals for recall

12   visits, as we've talked about.

13   A more recent systematic review

14   was Cochrane that included only RCTs and only

15   included one study. That was rated as very

16   low quality.

17   MR. MCINERNEY: Any further

18   discussion?

19   MS. SAMPSEL: Actually we have a

20   new member who joined. So, Mike, we're hoping

21   that could as a matter of public record,

22   introduce yourself as well as update any

1   changes that you may or may not have had to

2   disclosures or conflicts of interest.

3   MR. STOTO: Okay. Well, thank

4   you. Well first of all let me apologize for

5   being late, I had another important meeting I

6   had to go to today back at home.

7   I'm Mike Stoto. I'm on the

8   faculty at Georgetown University and I don't

9   have any changes to make to my disclosures.

10   MS. KHAN: Sorry. We're going to

11   be giving you a slip of paper also that will

12   state whether you have a two or three year

13   term on the Committee.

14   MR. STOTO: Okay.

15   MS. KHAN: So if you could just

16   announce that when you get your paper.

17   MR. STOTO: It's a lottery huh?

18   Two. Is that good or bad?

19   MR. MCINERNEY: Well the pay is

20   the same whether it's two or three years.

21   (Laughter.)

22   MR. MCINERNEY: Okay. So thanks

1   for reminding me, that introduction. So now

2   remind me, where are we.

3   MS. KHAN: Evidence.

4   MR. MCINERNEY: Evidence? Okay.

5   Any further discussion on evidence? Yes.

6   MR. BIALEK: I don't know if this

7   fits with the evidence discussion or further

8   down. But for the population here, two

9   consecutive years, if you're not in the same

10   plan for two consecutive years how is that

11   impacted with regard to the measure?

12   MS. ARAVAMUDHAN: The denominator

13   is conditioned based on enrollment

14   requirements for both years. So it would only

15   capture those in the denominator, so that is

16   adjusted for.

17   MR. MCINERNEY: Arjun.

18   MR. BIALEK: For the individuals

19   who are not enrolled for two consecutive years

20   which is, I mean, do you have data on the

21   proportion of the population that's not

22   enrolled for two consecutive years in a

 1   specific health plan? Especially Medicaid,

 2   Chip?

 3   MS. ARAVAMUDHAN: I believe we do

 4   have that data but it wasn't -- Do we have the

 5   two-year enrollment?

 6   FEMALE PARTICIPANT: I don't think

 7   it's in the application.

 8   MS. ARAVAMUDHAN: It's not in the

 9   application, but that was part of our

10   Committee review that we did in terms of

11   understanding the feasibility of these

12   measures. Either we went back to, you know,

13   90 day, 180 day, 11 out of 12 months and did

14   the whole iteration before we came up with the

15   conclusion that this was going to be feasible

16   and valid for the measuring of the plan at the

17   program level.

18   MR. BIALEK: So you don't have the

19   proportion of the population?

20   MS. ARAVAMUDHAN: Not in the

21   application, no.

22   MR. BIALEK: Why wouldn't you have

1   that -- out of the application?

2   MS. ARAVAMUDHAN: Yes, we have it

3   available. We can share it with you at some

4   point.

5   MR. BIALEK: That would be good,

6   thank you.

7   MR. VENKATESH: I was just going

8   to say that I think this measure has a couple

9   features to it that make it a much better

10   measure of access and something that I think

11   seems a lot stronger than the previous measure

12   that we evaluated. And that is that it

13   includes this concept of two visits.

14   And the language that was getting

15   used in the previous measure a lot was that,

16   you know, you needed to have one periodic or

17   comprehensive exam to have a pathway but there

18   really wasn't data, or there wasn't evidence

19   to suggest that by having one that you

20   therefore have a pathway.

21   To me when I see this measure and

22   interpretation it said this is a pathway

1   because it's suggesting that the second visit

2   suggests that hopefully that something happens

3   between the two. There's some construct for

4   continuity then. So to me this is a much

5   better measure of access.

6   And also I think we shouldn't

7   overplay some of the level of evidence work

8   from the Cochrane review, because if you think

9   about what happens in the Cochrane review the

10 question they're asked is, right, does this

11 having a periodic evaluation lead to some

12 health outcome change.

13   But if we're viewing this as a

14 measure of access, so within the National

15 Quality structure if you think about the

16 community domain and access underneath that,

17 that's not the question that they asked when

18 they reviewed a lot of this evidence.

19   And so if you are looking for an

20 access measure and something that has that

21 kind of continuity element to it I think this

22 addresses those in some ways better so than

1 just a straight utilization measure of a

2 single visit. And I think it's good for that

3 case.

4   MR. STOTO: So I guess the issue

5 with this one is that they call it care

6 continuity and I wonder whether or not just

7 two visits in two subsequent years really is

8 a measure of continuity.

9   I mean, continuity I think usually

10 means that all of your services are

11 coordinated from a variety of different

12 providers and so on. And this strikes me as

13 not getting at that concept.

14   MS. ASOMUGHA: That's precisely

15 what I was going to say as well. It really

16 doesn't get at that whole continuity question.

17 I also -- And I stepped out right when

18 somebody was asking a question about what

19 happens if they change plans or doctors or

20 whatnot, does that still get followed.

21   So I don't consider it to be the

22 best measure of access or continuity for that

1 matter.

2   MR. MCINERNEY: Yes.

3   MS. MCKANE: And mine is similar.

4 I had to step out so if this was covered I

5 apologize. But I was wondering how you

6 decided on just two years. And, you know, the

7 same thing, when I think in continuity of care

8 I think in longer terms. But I also recognize

9 that with the population that may be difficult

10 to track. So I was wondering how you arrived

11 at two years as your period?

12   MS. ARAVAMUDHAN: So this is

13 really difficult for us, right? And in terms

14 of measuring you would hope that the primary

15 use of any measure is more longitudinal. That

16 the program or plan will pick a measure and

17 then keep it for over time so they can see

18 change over time.

19   So if you think about this measure

20 and then look at it over time then that trend

21 data is really, really useful even though the

22 population might shift between year one, year

1   two. Year two, year three or year three, year

2   four.

3   There is some continuity built

4   into that that helps at a program again

5   bringing us back from the individual patient,

6   individual provider, to looking at this as an

7   access measure at the plan level, program

8   level, how does that work. I think that's the

9   thought process that went into looking at the

10   measure the way it is.

11   MR. CRALL: Yes and the other is

12   just looking empirically and noticing the

13   falloff. The longer you make that period the

14   smaller the, you know, the proportion of the

15   population that you can actually look at. So

16   I mean we actually look at it empirically.

17   MR. MCINERNEY: All right. Any

18   further discussion on 1A, evidence? Yes.

19   MR. STOTO: One more thing. I

20   mean reading through this whole set of

21   measures it struck me you guys did a really

22   good job in trying to do the best you could

1   with the data you had. And in some cases you

2   did a very good job I thought.

3   But in this case it seemed to be

4   too much of a stretch that this particular

5   proposed measure would actually address

6   continuity. Maybe it's a useful thing to have

7   but I certainly want to call it continuity.

8   And I can't say that the evidence that's cited

9   about the importance of continuity relates to

10   this, was addressed by this measure.

11   MS. ARAVAMUDHAN: The continuity

12   of care is the name of the measure. If there

13   is a better way to express it I think we would

14   be open to it. But the intent of this measure

15   is simply to say dental home one here, dental

16   home and then see if that patient was within

17   the system. So definitely if there is a

18   different way to express the measure title we

19   are open to that suggestion.

20   MR. MCINERNEY: No further

21   discussion. Let's vote on evidence please.

22   MS. ROBINSON-ECTOR: Okay. For

1 evidence 1 is high, 2 is moderate, 3 is low,

2 4 is insufficient evidence, 5 is insufficient

3 evidence with exception. Voting is open.

4   Okay. Just waiting on one vote.

5 All of the votes are in and voting is now

6 closed.

7   For evidence, 0 voted high, 11

8 voted moderate, 5 voted low, 4 voted

9 insufficient evidence and 2 voted insufficient

10 evidence with exception.

11   MR. MCINERNEY: So if we add the

12 11 moderate and the 2 insufficient with

13 exception that gets to 13 out of 22.

14   MS. KHAN: So it's 59 percent.

15   MALE PARTICIPANT: All right, if

16 it was 13 out of 21 it would have been good.

17   MS. KHAN: So we'll just follow

18 the same procedure we did before. At the end

19 we can decide, or you all can decide as the

20 Committee whether or not you want to do an

21 overall vote or not.

22   MR. KROL: Okay to go for the

1   performance category?

2   MR. MCINERNEY: Yes, David.

3   MR. KROL: So for performance gap

4   extensive data are made available that

5   demonstrate a considerable variation and less

6   than optimal performance of annual access to

7   dental services, though not specifically using

8   this process measure, these disparities are

9   found by age, race, ethnicity, geography as

10   well as family income, insurance status and

11   education.

12   MR. MCINERNEY: Any further

13   discussion on performance gap? Yes?

14   MS. MCKANE: I have a question.

15   It says, I was just reading whatever this is

16   -- Sorry. I was reading the summary and it

17   says that these data however do not relate to

18   the proposed measure of continuity of care so

19   the data aren't provided for this. I mean I

20   totally agree that there is disparities in

21   care, but the data that applied aren't related

22   directly to this measure?

1   Okay. I just wanted to clarify

2   that because that's what I was reading and I

3   just wanted to make sure.

4   MS. ARAVAMUDHAN: Yes. If we had

5   cited something from the literature then we

6   probably had made a comment that that is not

7   very specific to this measure. But our own

8   testing data that's including in the measure

9   testing form is definitely against this

10   particular measure.

11   MS. MCKANE: Okay. Thank you.

12   MR. MCINERNEY: Okay. Any further

13   discussion on performance gap? Okay. Let's

14   vote please.

15   MS. ROBINSON-ECTOR: For

16   performance gap, 1 is high, 2 is moderate, 3

17   is low and 4 is insufficient. And voting is

18   now open.

19   All votes are in and voting is now

20   closed. For performance gap 4 voted high, 13

21   voted moderate, 3 voted low and 2 voted

22   insufficient.

1   MR. MCINERNEY: Okay.

2   MR. KROL: So high priority. Data

3 are made available for the percentage of

4 children who have untreated decay. Data was

5 previously provided on higher disease rates in

6 certain populations, minority and poor

7 populations, and the specific disease, dental

8 care, is noted as noted as the most common

9 chronic disease of childhood.

10   MR. MCINERNEY: Any further

11 discussion on priority? Okay then let's vote.

12   MS. ROBINSON-ECTOR: For high

13 priority, 1 is high, 2 is moderate, 3 is low

14 and 4 is insufficient. And voting is now

15 open.

16   All of the votes are in and voting

17 is now closed. For high priority 7 voted

18 high, 10 voted moderate, 3 voted low and 2

19 voted insufficient.

20   MR. KROL: So which is 2A,

21 reliability and validity. So 2A, let's see.

22 Yes, the only things that I had down here you

1   could probably ignore. They're my nitpicking

2   about the language and the numerator and

3   denominator. It's just left out, the age

4   group and the denominator. But I think that's

5   a nitpick that's not an issue.

6   And then just back to the whole

7   logic about who provides services as far as

8   the rendering provider taxonomy code. And

9   then there's that one code that would qualify

10   but it has a notation that states it's not

11   applicable for this measure. We talked about

12   this in a previous measure, didn't quite make

13   sense. Otherwise numerator, denominator

14   exclusions are clearly described.

15   Let's see. And then specifically

16   about reliability testing. Well I'm talking

17   about both. Okay. So for reliability, wasn't

18   done using statistical tests with the measure

19   as specified. The authors make a case that

20   because the measure relies on standard data

21   fields commonly used in administrative data

22   that integrated reliability does not apply.

1   As for the flow chart that we got,

2   since they did do empirical validity testing

3   with patient-level data, I'm using the rating

4   from the validity testing of the patient-level

5   evidence. And that's just following the

6   protocol of how you put it in.

7   So as far as validity testing for

8   the measure it assessed critical data element

9   validity, empirical measures for validity face

10   and then potential threats. The critical data

11   element validity focused on the accuracy of

12   the dental procedure codes reported in the

13   plan's data. This was done looking at whether

14   the code in the plan's data was supported by

15   the dental record. They found agreement,

16   concordance between dental records,

17   administrative claims data with good numbers,

18   kappa point 642 which is substantial.

19   Face validity was gauged through

20   feedbacks elicited through public comment

21   periods, stakeholder feedback, though no

22   measure of that face validity was obtained,

1   though they did state that unanimous agreement

2   among the group of stakeholders that the

3   calculated measure can be used to evaluate

4   quality of care was obtained.

5   And additional face validity test

6   via consensus process to determine the final

7   denominator definition regarding length of

8   enrollment, six months. They also looked at

9   whether long, meaning great than six month

10 gaps in enrollment, might be a threat to

11 validity and they found it would not be.

12   MR. MCINERNEY: Any further

13 discussion on reliability? Okay. Let's vote

14 please.

15   MS. ROBINSON-ECTOR: For

16 reliability, 1 is high, 2 is moderate, 3 is

17 low and 4 is insufficient. And voting is

18 open.

19   All votes are in and voting is now

20 closed. For reliability 4 voted high, 16

21 voted moderate, 2 voted low and 0 voted

22 insufficient.

1   MR. KROL: Yes, so I'm not sure

2   that when -- Essentially it defaulted from

3   reliability to validity. So it's sort of

4   redundant, I'm not sure if you want us to go

5   through that again with the validity? Okay.

6   Do you want me to repeat what I

7   said for the reliability and validity? Okay.

8   Thank you.

9   MR. MCINERNEY: Any discussion on

10   validity? Yes?

11   MR. STOTO: I'm trying to find the

12   exact spot. But I think I recall that reading

13   that the RAND/UCLA Delphi process method

14   didn't actually consider this measure itself.

15   So they can't really cite that as in support

16   of the validity if they didn't support this

17   measure. Is that correct?

18   MS. ARAVAMUDHAN: You mean for the

19   face validity of the measure?

20   MR. STOTO: The face validity,

21   yes.

22   MS. ARAVAMUDHAN: So yes, it was

1 part of the Delphi process that it was

2 considered. I'm not sure what we wrote on the

3 form. But we also, an array of Delphi

4 processes is we go at it iteratively at

5 different stages in the measure development

6 process.

7 So initially as we do an

8 environmental scan and then when we later on

9 do the draft measure concept. And then as we

10 do the measure, so definitely in the later

11 stages of the game this was included. This

12 measure was not identified in the

13 environmental scan, that's the section that

14 you might be referring to.

15 MR. STOTO: So was this particular

16 version of the measure -- I mean, I can see

17 that continuity for sure would score high in

18 face validity. But this idea about received

19 a comprehensive evaluation in both years --

20 MS. ARAVAMUDHAN: Definitely.

21 MR. STOTO: Was that the specific

22 one that was scored high there?

1   MS. ARAVAMUDHAN: Yes. When we

2   have our draft measures, before we test we

3   send it out once. Then in between, once we

4   have all the testing data, before we actually

5   finalize the measure we take another check on

6   face validity.

7   Then after we finalize the

8   complete specs and all the i's are dotted, t's

9   are crossed, we set it out again for a vote.

10   So we have multiple places where we check for

11   face validity.

12   MR. MCINERNEY: Okay. Any further

13   discussion on validity? All right, let's vote

14   please.

15   MS. ROBINSON-ECTOR: For validity,

16   1 is high, 2 is moderate, 3 is low and 4 is

17   insufficient. And voting is now open.

18   All votes are in and voting is now

19   closed. For validity 0 voted high, 16 voted

20   moderate, 5 voted low and 1 voted

21   insufficient.

22   MR. STOTO: Could I -- I'm sorry

1   to come back to it, but I found the language

2   that I was looking for. I mean, can I bring

3   it up again? Yes.

4   This is in the section that says

5   face validity in the Appendix about 2A, 2B and

6   so on. It says, "Continuity was identified in

7   the Delphi process and although care

8   continuity was not explicitly evaluated

9   through the Delphi process the measure

10   concepts for oral evaluation and specifically

11   a comprehensive or period oral evaluation were

12   evaluated."

13   Oral evaluation is a central

14   component of the proposed method and got a

15   high score. So this comes back to the first

16   thing that we talked about with this measure,

17   is that oral evaluation scored well in terms

18   of validity. But not, as I read this text

19   here, as a measure of continuity. That's the

20   concern that I have.

21   MS. ARAVAMUDHAN: So that

22   pertained to the environmental scan results

1 and how we use the Delphi process to wiggle

2 down the concepts that we were trying to go

3 ahead and double up the measures with.

4   So initially when we got our list

5 of 200-odd measures that were out there to be

6 part of the scan this was not included in that

7 list. So it did not go through that formal

8 Delphi process at that point in time. That's

9 what that section is talking about in terms of

10 environmental scan. I'm trying to pull that

11 up quickly, but I'm hoping that it's listed

12 under that section.

13   Later on, as our process works, we

14 have our committee which then looks at all of

15 these measures and votes on, okay, it passes

16 this step, passes this step. And when then we

17 go to take formal votes through the broader

18 DQA which has 32 different organizations

19 sitting at the table, and so it has to pass

20 all those votes before it, you know, comes to

21 any kind of final step.

22   And there are at least two

1   different steps of interim reports and

2   consensus building before any measure is

3   finalized.

4   MR. STOTO: Then I have a very

5   specific question. And that is were the

6   experts asked whether this measure, as

7   currently stated, is a measure of continuity?

8   MS. ARAVAMUDHAN: The measure has

9   -- I'm sorry.

10   MR. STOTO: That's the question.

11   And the way I read this it says no, but maybe

12   this is incorrect.

13   MS. ARAVAMUDHAN: So we have

14   always called this care continuity, but we

15   have not asked that specific question, does

16   this reflect care continuity. This measure we

17   have always called it a care continuity

18   measure.

19   MR. CARILLO: Why not just call it

20   two-year care continuity?

21   MR. STOTO: Okay.

22   MS. ARAVAMUDHAN: And we can

1   editorially revise it. If it's not, if in

2   your expertise this doesn't really address

3   that, we're happy to revise it and simply call

4   it oral evaluation over two years.

5   MR. STOTO: Or two year care.

6   MS. ARAVAMUDHAN: Or two year care

7   continuity, whichever works.

8   MR. KROL: Start over. So these

9   are administrative data so as long as someone

10   decides to build for the service it will be

11   recorded in the normal operation of business

12   care. Most of these electronic billing

13   processes so they'll be captured

14   electronically. And there shouldn't be

15   additional cost to implement this data

16   collection.

17   MR. MCINERNEY: Any other comments

18   on feasibility? All right, let's vote please.

19   MS. ROBINSON-ECTOR: Feasibility,

20   1 is high, 2 is moderate, 3 is low and 4 is

21   insufficient. And voting is now open. Okay.

22   We're just waiting on one vote.

1   We still need one more vote.

2   Sorry, we're going to have re-vote it. Must

3   have lost one. Okay, it went through.

4   So for high there are 11 votes.

5   For moderate there were 10 votes. And for low

6   there were 1 votes.

7   MR. KROL: I'm going to stop

8   turning it off, you guys got me all nervous

9   about leaving it on.

10   Currently used in Texas for their

11   Medicaid and Chip programs. It's also being

12   suggested for use in Connecticut. As far as

13   -- It's not quite clear if there's evidence

14   that it's been shown to improve care or

15   quality, but likely it's just too early as

16   it's just been implemented.

17   And it doesn't seem to be that

18   there is any evidence that this will have any

19   negative consequences to patients. Although

20   unless providers feel that the burden of

21   measures like this, in doing all this for

22   Medicaid, makes them decide to leave Medicaid.

1 I don't know if that would necessarily be an

2 issue because I think this was specific to

3 Medicaid versus the payers.

4   But I know there's already a

5 challenge of trying to get providers to

6 participate in Medicaid, if this is seen as a

7 burden to them then it's just one more reason

8 to leave.

9   MR. MCINERNEY: Any further

10 comments on usability? All right, let's vote

11 please.

12   MS. ROBINSON-ECTOR: For

13 usability, 1 is high, 2 is moderate, 3 is low

14 and 4 is insufficient information. And voting

15 is now open.

16   All of the votes are in and voting

17 is now closed. For usability there were 4

18 vote for high, 13 votes for moderate, 3 votes

19 for low and 2 votes insufficient information.

20   MR. MCINERNEY: Okay. Well if you

21 all remember on the first critical vote we

22 reached only 59 percent, one percent short of

1   the 60 percent required to do a final vote.

2   But I'll ask the group would we want to do a

3   final, overall suitability for endorsement

4   vote? Go ahead.

5   MR. INGE: I vote no. And to stay

6   consistent with our process from the previous.

7   MR. MCINERNEY: Okay.

8   MR. VALDEZ: And I second.

9   MS. ARAVAMUDHAN: We agree.

10   MR. MCINERNEY: All right. So we

11   have some recommendations to not vote, to

12   delay the vote. All those in favor of

13   delaying the vote? Okay, great. We'll delay

14   the vote.

15   Well we've earned the break. A 15

16   minute break.

17   MS. SAMPSEL: No, I think it's

18   five minute break.

19   MR. MCINERNEY: Only five minutes?

20   MS. SAMPSEL: Maybe 10. How about

21   10?

22   MR. MCINERNEY: All right, 10.

1   We'll compromise at 10, all in favor of 10

2   minutes. Ten minute break. Thank you very

3   much.

4   MS. ARAVAMUDHAN: Thank you, for -

5   -

6   MR. MCINERNEY: Thank you.

7   (Whereupon, the meeting in the

8   above-entitled matter went off the record at

9   3:45 p.m. and went back on the record at 3:57

10   p.m.)

11   MR. MCINERNEY: We'll try and get

12   through them this afternoon, but if for one

13   reason or another we get hung up on the first

14   we can do the second one, add that to

15   tomorrow's work.

16   So we now have, these measures are

17   our measures and we have the AHRQ developer

18   here, Pam Owens, want to say a word or two?

19   MS. OWENS: Sure. My name is Pam

20   Owens. I'm the scientific lead of the AHRQ

21   quality indicator so I'll be representing the

22   two measures this afternoon, if we get to two,

1   and the six measures tomorrow. I'll provide

2   a broad overview that basically encompasses

3   all of the measures in just a moment.

4   But on the phone I have Patrick

5   Romano, he is a pediatrician and internist at

6   UC Davis and is the actual measure developer.

7   And so Patrick has all the clinical knowledge

8   and I have the data knowledge and hopefully

9   together we can answer your questions.

10   MR. MCINERNEY: Okay. And the

11 first measure that we're going to discuss is

12 the gastroenteritis admission rate, which is

13 on Page 37 of your worksheet. This measure is

14 admissions for principle diagnosis of

15 gastroenteritis or a principle diagnosis of

16 dehydration with a secondary diagnosis of

17 gastroenteritis per 100,000 population, ages

18 3 months to 17 years. And it excludes cases

19 transferred from another facility, cases with

20 gastrointestinal abnormalities or bacterial

21 gastroenteritis and obstetric admissions.

22   Now, did you want to say any word

1   about this measure, please?

2   MS. OWENS: That would be great.

3   So just to give you a broad overview, what

4   we'll be talking about this afternoon and

5   tomorrow are what we would call in the family

6   of prevention quality indicators.

7   The two today are part of the

8   pediatric quality indicator group. So they're

9   prevention quality indicators, but geared

10   towards kids.

11   All of these measures are

12   avoidable hospitalizations or ambulatory care-

13   sensitive condition indicators. They were

14   designed to assess population access to

15   timely, high-quality outpatient services for

16   the purposes of managing a chronic disease,

17   preventing complications of a chronic disease

18   or diagnosing acute illnesses before they

19   progress to inpatient treatment.

20   These are not measures of hospital

21   quality but rather measures of potentially

22   avoidable hospitalizations if appropriate

1   outpatient care, other healthcare services or

2   community services was accessed and received.

3   These measures have a denominator

4   of a population base. In other words it's a

5   geographic orientation, it is not at the

6   hospital level. And these measures are

7   derived from the healthcare cost and

8   utilization project which is a voluntary

9   federal, state, private industry partnership

10   that collects data from 46 states, all

11   inpatient hospital discharges from 46 states,

12   that includes 4,651 hospitals in 2011. And

13   roughly that turns out to be five million

14   pediatric discharges, including births, per

15   year.

16   So just so you have a sense that

17   this is a very comprehensive database, the

18   database is actually grounded in the uniform

19   bill. This is what the hospitals submit as

20   their bill. So all of the data elements are

21   standardized through the National Uniform

22   Billing Committee so every data element has a

1   standard definition. So when we talk about

2   principle diagnosis versus secondary

3   diagnosis, that has a distinct meaning.

4   And it initially it is collected

5   as part of the routine process to get

6   reimbursement. We get it from the billing

7   side. If CMS uses it it's the claims side.

8   In other words it's adjudicated. So just to

9   give you some context on the data.

10   And, Patrick, do you want to say

11   anything about the gastroenteritis measure

12   itself?

13   MR. ROMANO: Yes. This is Patrick

14   Romano, can everyone hear me?

15   MR. MCINERNEY: Yes.

16   MR. ROMANO: Okay. Thank you.

17   Yes, I just wanted to add that this measure

18   differs from some of the other prevention

19   quality indicators that we'll be talking about

20   because it has two components to the logic.

21   So it allows for a principle diagnosis of

22   gastroenteritis or dehydration. But if the

1   principle diagnosis is dehydration then there

2   must be a secondary diagnosis of

3   gastroenteritis.

4   And just to give you a brief

5   historical perspective on that. So this

6   started out as two separate indicators in our

7   development process but as we went through our

8   delphi process with a series of expert panel

9   discussions and testing of the indicators it

10   was decided to bring the two indicators

11   together, to combine them, to improve the

12   reliability. And also it was felt that

13   hospitalizations for dehydration with other

14   identified causes were not of as much

15   interest.

16   They were more likely to be due to

17   underlying medical conditions, chronic

18   conditions, that a child might have. And not

19   as likely to be amenable to ambulatory care

20   and urgent care.

21   So that's why these two indicators

22   were brought together as you see the current

1   construction.

2   So I'll turn it back over now to

3   the panel.

4   MR. MCINERNEY: Thank you very

5   much. Now time for discussion, Michael or

6   Jacqueline, who --

7   MR. CARILLO: Okay. A question?

8   MR. MCINERNEY: Sure.

9   MR. CARILLO: Now, we have

10   principle diagnosis which is, you know, put

11   together after the fact. You have first

12   diagnosis, second diagnosis, which as a

13   patient comes in. Can you clarify are we

14   talking about the principle diagnosis and then

15   talking about the secondary diagnosis from the

16   other side?

17   MR. ROMANO: Well both the

18   principle diagnosis and the secondary

19   diagnosis are established after the patient

20   leaves the hospital. They are defined in

21   regulation as diagnoses that are determined

22   through review of the medical record, usually

1   within 24 to 72 hours after the patient leaves

2   the hospital.

3   The principal diagnosis is the

4   principally responsible for occasioning the

5   admission of the patient to the hospital for

6   care. And the secondary diagnoses represent

7   other diagnoses that were established during

8   the hospital stay or were pertinent to the

9   treatment to the patient in the hospital.

10   So neither of these -- I think you

11   may be thinking of the admission diagnosis,

12   which is something completely different and

13   isn't used in the AHRQ I algorithms.

14   MR. CARILLO: Thank you.

15   MR. MCINERNEY: Yes. And from my

16   perspective it's sometimes in my mind it's

17   sort of a tossup, the coder who looks at the

18   admission and decides how to code this,

19   whether they would put dehydration first or

20   gastroenteritis first. And if they did put

21   gastroenteritis first, I mean dehydration

22   first, you would miss a significant number of

1   children with gastroenteritis.

2   So I think that makes sense to me

3   that if the dehydration is the first code then

4   checking what's next. And if it's

5   gastroenteritis then include it. That makes

6   sense, logically.

7   David.

8   MR. KROL: Just, I see a comment

9   here that may address my question but I don't

10 have the context for it. And that's is this

11 measure looking at admission versus community

12 management? Or admission versus community

13 management and emergency

14 department/observation unit management?

15 Because, you know, a scenario where an office

16 pediatrician or a home decides not to manage

17 any of these kids and sends them all to the

18 emergency department and lets the emergency

19 department decide whether they get admitted or

20 not is very different from the community

21 managing them well, not necessarily sending

22 them to the emergency department to be tanked

1   up or oral rehydration attempted.

2   Can you, I see this, it starts

3   with concur, but I don't know what that's

4   responding to and maybe that addresses that.

5   MS. MOLINE: David, transfers from

6   another organization or another facility are

7   excluded. So it's only from the community.

8   So it's --

9   MR. KROL: No, no. No, I'm sorry.

10 I misspoke. I'm just saying, so say a patient

11 goes on their volition to the emergency

12 department or an office sends a child to an

13 emergency department to get IV'd in the ED and

14 let them decide, you know, that happens.

15   At least as a resident that

16 happened quite a bit where, you know, the

17 office decided they didn't want to put an IV

18 in so they sent them to ED, or didn't have the

19 time to start an oral rehydration in their

20 office so they'd send them to the ED, for us

21 to do that and then we'd send them home and

22 not admit them. So --

1   MS. OWENS: So the attribution in

2   terms of where the problem lies in the

3   outpatient arena, whether that be, you know,

4   that there's increased utilization in the ED,

5   and that's, you know, maybe that's patient

6   choice whether it be in the community. Maybe

7   it's actually patient non-compliance with, you

8   know, with some sort of treatment that

9   somebody prescribed. Right?

10   That's not what this measure is

11   about. This measure is at the county level

12   are there higher rates of inpatient

13   hospitalization for gastroenteritis. Now

14   where that problem lies in terms of access to

15   outpatient care or community characteristics,

16   this measure doesn't say what that is. If

17   that helps.

18   And there is no, in this measure,

19   there is no measurement of ED utilization

20   other than the inpatient stay may have started

21   in the ED.

22   MR. MCINERNEY: While we're on the

1 subject, the problem of the observation

2 status, because as I understand it now CMS

3 defines a hospitalization as two midnights.

4 And we know in pediatrics we can have children

5 be admitted for 24 hours and go home without

6 hitting that two midnight and therefore it's

7 not called an admission. And I don't know,

8 what do we do with that situation?

9   MS. OWENS: So in this particular

10 database, if that observation stay then

11 becomes longer than two days it would be

12 counted as an inpatient hospitalization. We

13 have a different database that captures

14 observation stays that would count for those

15 that are less than two days.

16   MR. MCINERNEY: Oh, okay.

17   MS. OWENS: So they're not in this

18 data.

19   MR. AUERBACH: Just clarify about

20 the comment -- Was just going to clarify about

21 the comment that you made in response to the

22 data because I think it will apply to a number

1   of other metrics that we're looking at later.

2   Are you saying that this should

3   not be interpreted as a measurement of quality

4   of care? Yes? Okay.

5   So can I ask then for a

6   clarification about that? So when are we,

7   when should we consider these to be indicators

8   of quality of care versus something else? So

9   if it's not a measure of quality of care, what

10   is it?

11   MS. OWENS: Well, I mean, in the

12   sense that it could be a measure of access.

13   MR. AUERBACH: Sure.

14   MS. OWENS: It could be a measure

15   of quality. I mean, what I'm saying is we are

16   not attributing it to any one thing other than

17   we know that this particular hospitalization

18   was preventable if certain things had fallen

19   into place.

20   MR. AUERBACH: Sure. So again, I

21   guess partly this is really a question for

22   NQF. Do we give guidance for certain measures

1   that this should not be interpreted as a

2   measure of quality because in fact, I mean, it

3   also could be a measure of social determinants

4   of health or greater poverty in a community.

5   Or a population that's at greater risk for

6   social reasons, correct?

7   So I guess I'm just asking for

8   clarification about how do we tell people

9   looking at these that get approved to

10 distinguish between those that really are a

11 reflection of quality of care and those that

12 may not be?

13   MS. MUNTHALI: So you'd be looking

14 at the measure as it's specified and the

15 intent of it as Pam has stated. So we will

16 make sure in the report that the measure is

17 indeed, well, through your evaluation that it

18 is indeed evaluating what it says it's going

19 to evaluation. Attribution is where it is

20 supposed to be. The evidence supports the

21 measure. All of those things will support

22 the, you know, the intent of the measure.

1   MS. OWENS: And can I ask if

2   Patrick wants to, you know, since he was from

3   the beginning in terms of development, do you

4   have any other things you'd like to add to

5   this conversation, Patrick?

6   MR. ROMANO: Yes. Just two quick

7   points basically. One is I think perhaps a

8   more general way of describing these measures

9   would be that they're measures of health

10 system performance.

11   So quality of course is part of

12 that, but when we think about health system

13 performance it's a broader concept. NQF has,

14 for example, evaluated and endorsed measures

15 of efficiency which is another component of

16 health system performance. It's sometimes put

17 under a broader definition of quality but it's

18 really kind of a bit separate conceptually.

19   So I think that's the way we

20 conceptualize these from the beginning.

21   In terms of the comment about

22 observation units, I just wanted to add that

1   of course CMS has not yet implemented the two

2   midnight rule. Many of us who are on the

3   front lines are thankful that they have

4   deferred the two midnight rule. But

5   nonetheless it's probably coming. I think as

6   the two midnight rule is implemented obviously

7   we'll have to revisit these indicators and the

8   specifications. Look at the impact of that.

9   You know, right now I think many

10   hospitals are effectively working with a one

11   midnight rule which means that observation

12   stays have to be pretty short and are easier

13   to distinguish from hospitalizations. But as

14   we go to a two midnight situation obviously

15   there's going to be more overlap, sort of

16   conceptually between what counts as an Ob stay

17   and what counts as a hospitalization.

18   So that clearly will have an

19   impact, perhaps more for the Medicare

20   population than for this population of

21   children. But it will cause some re-

22   examination and re-analysis and perhaps re-

1   specification of the indicators.

2   So we're just working now with

3   what we have based on historical data over the

4   last decade.

5   MR. STOTO: So this is an

6   interesting question, I actually was talking

7   about it in class yesterday. And I hope what

8   I'm about to say is right, so let me know if

9   I've missed it.

10   What I have always understood

11   about these measures is that they are not a

12   measure of the quality of the care provided by

13   the hospital to which the children are

14   admitted. But they are a measure of the

15   performance of the healthcare system in the

16   communities from which they come. And I think

17   they --

18   MR. ROMANO: Exactly.

19   MR. STOTO: Yes. And I think

20   that's an important distinction and an

21   important set of measures to have in this

22   group that we're considering now. Is that?

1 That's correct?

2   MR. MCINERNEY: So we'll start now

3 at the end of the table and work our way up.

4   MR. ROMANO: Perfect from our

5 perspective.

6   MR. AUERBACH: So I'm a little

7 uncomfortable with that. Because I think that

8 that, normally if you said health system

9 performance I would assume that what you're

10 saying is the healthcare provider in the

11 community, or the primary care provider, has

12 somehow failed in terms of the pediatrician in

13 this case.

14   I mean, I like a notion writ large

15 of health system performance that includes

16 poverty and, you know, the larger social

17 determinates. But I think that that's unfair,

18 you know, in this context.

19   I think we don't currently hold

20 our health system accountable for addressing

21 all the social determinants of health. We

22 might want to but we don't. And so that's why

1   I think it implies, I think the term health

2   system and performance does imply the

3   traditional way we thought of a health care

4   provider having responsibility. Somebody else

5   has failed in that system other than the

6   hospital. And I think it's more complicated

7   than that.

8   MR. STOTO: It's a really deep

9   issue. But I think that as we're moving to a

10 world of population health where we have to

11 bear in mind that health is a shared

12 responsibility, having measures like this that

13 work well, if understood properly, are

14 important.

15   So if a community has a high

16 number and it doesn't say who's at fault, but

17 it does say something needs to be looked at.

18 And so if it's interpreted that way I think

19 it's an important and useful set of measures

20 to have.

21   MS. SELLERS: So this is all kind

22 of leading into what I was going to circle

1   back with you about, which is your reports.

2   And forgive me for not being very familiar

3   with how they look when they come out.

4   But do you have a systematic way

5   of gathering committee input on, you know,

6   what this a measure of and how this measure

7   should be used and what it should not be

8   interpreted as? And would that be a place

9   where we could elaborate on this being a

10   measure of community health or community

11   health system performance or whatever, you

12   know, whatever language there is consensus on?

13   MS. ASOMUGHA: I'd also add to

14   that that when it comes to how we measures,

15   say for instance from CMS, when we have not

16   only the pay for reporting but pay for

17   performance, the issue that would definitely

18   arise is how dare you CMS and any other payer

19   decide that we're accountable for something

20   that the other part of the system had more of

21   the responsibility over.

22   So if the hospitals are being

1   excluded from this and it's more a measure of

2   the community health system, I could foresee

3   providers saying that's not our fault. And if

4   we did it the other way I could see hospitals

5   saying it's not our fault either. They do it

6   now.

7   So just --

8   (Off microphone comment.)

9   MS. ASOMUGHA: Well it doesn't

10   matter, you're right, it doesn't matter what

11   we do, they're going to complain. But that

12   being said, who's the accountable party is

13   probably the most important, to me, question

14   to be answered. And we do need to have these

15   kinds of measures going forward, whether it

16   creates a stink or not, this is the future and

17   it's now.

18   MR. VENKATESH: So I think what

19   this discussion starts to get to, which is

20   something that came up in our workgroup

21   discussion around a lot of these measures,

22   requires us to kind of go back to where the

1   measure specified in the denominator

2   statement.

3   And this is the discussion that we

4   kind of had earlier in the level today about

5   where this committee is going to have to do

6   some work around levels of analysis.

7   And so the denominator statement

8   for this measure, and correct me but I think

9   it's going to be very similar across a lot of

10   the PQIs, is that it's a population ages 3

11   months to 17 years, so that's the age for this

12   measure, in a metropolitan area or county.

13   And so the measure is being

14   specified is metropolitan area MSA,

15   metropolitan statistical area, so think of it

16   then as that if we're endorsing it just by a

17   metropolitan statistical area or just by a

18   county, then that's all the result that you

19   get out of it is.

20   If it's used outside of that

21   that's kind of a secondary discussion we can

22   have. But if we just start with the first

1   part of the discussion, which is metropolitan

2   statistical area or county, then I think the

3   next question we have to ask is, is that a

4   meaningful number. And so I think of this, I

5   always take this back to where I work and how

6   that means locally.

7   And so in New Haven County, our

8   PQI rate is considerably higher than the

9   county to the south of us, Fairfield County.

10   That is partially driven by social

11   determinants of health. It may be driven by

12   a variety of market structure factors and a

13   variety of things.

14   There's an adjacent county that

15   has a very low number. That's because their

16   admission would actually be counted in our

17   county, because we have the hospitals. And so

18   the -- And the reason it's calculated that way

19   is because when you only have hospital data to

20   calculate from you're not calculating based on

21   the patient's residence. Although this

22   specifies residence.

1   And so the reason I just bring

2   this up is that thinking about it that way if

3   a county has a lot more gastroenteritis than

4   another county, is that meaningful information

5   from which you can glean things about any of

6   those things? Efficiency, access, quality,

7   any dimension, to then do actually even

8   something about it?

9   So I think it has to be meaningful

10 in the first place, at the county level. Or

11 meaningful at the MSA level. And then it has

12 to be something that you could do something

13 with. And I think that's true for, many of

14 the PQIs do fit that construct somewhat better

15 where I could see there being opportunities

16 for quality improvement and things along those

17 lines.

18   In the case of gastroenteritis it

19 seems harder for me. Because I'm not sure

20 what I would do if we have more

21 gastroenteritis in kids unless we think that

22 -- Unless there's feasibility to that being

1   how care is structured around access to

2   community-based care for gastroenteritis and

3   that's not necessarily, I don't think, always

4   the case.

5   And so that's why I think there's

6   a challenge with these measures. But I think

7   we need to be specific when we talk about it

8   at what the denominator we're talking about is

9   each time, because that impacts whether or not

10   we think it's valid. Whether or not we think

11   it's useful.

12   MR. CARILLO: Yes, I want to go

13   back to John's point. I mean, there's a lot

14   of studies, classic studies, that show that

15   the impact on health, the attributable impact

16   on health of social determinants surpasses

17   that of healthcare. And this speaks also to

18   the denominator issue in terms of what is the

19   social conditions in a particular area that

20   you're capturing.

21   So I mean I wonder have there been

22   any studies trying to look at to separate the

1 availability of healthcare in the setting of

2 certain PQIs? Because certainly, I mean, it's

3 a big issue.

4   Now you can say the two travel

5 together. I mean travel to healthcare and

6 adverse social deterministic conditions do

7 travel together. But I think that it's an

8 important issue to consider with this measure,

9 these measures.

10   MS. FRAZIER: I just want to

11 reemphasize the system, this concept of health

12 system, which I think is the quandary we find

13 ourselves in when we're trying to really, as

14 someone who works in the community, trying to

15 figure out how to impact change around

16 population health when we start thinking about

17 system responsibility it turns into nobody's

18 responsibility.

19   So I know that the goal is to

20 create population health measures and I agree

21 with that. I'm just trying to reconcile the

22 need to have something to have actionable at

1 a community level because we all rally around

2 this population health conversation. And this

3 is part of the other work that I'm doing on

4 this population health committee, that

5 committee is around trying to figure out how

6 to rally the troops to create some actionable.

7   So these measures, even though

8 they need to have a base of population health

9 as a denominator from a scientific

10 perspective, but I think in looking at it as

11 only a measure of something called a system I

12 think is also too broad in my mind too. It's

13 probably way to broad to figure out how do you

14 tackle this thing called not a system, it's a

15 system of, you know, impact. I don't know how

16 you'd tackle that?

17   MR. MCINERNEY: Anybody else?

18   MR. BIALEK: Yes, I need a little

19 help understanding the user of this particular

20 measure, because I think that's really key.

21 If it's -- And if we approve the measure

22 ultimately, is it limited to the county and

1   city? Or is it a measure that can be taken

2   and let's say CMS use it to rate individual

3   physicians?

4   MS. OWENS: So a couple things.

5   The PQIs have been used in the national

6   healthcare quality report and the national

7   healthcare disparities report to say how we're

8   doing as a nation with respect to these.

9   In other words, where does the

10   nation need to prioritize whether it be access

11   to care, whether it be community-level

12   initiatives, that kind of thing around various

13   conditions. So that's the broad stroke.

14   These indicators have also been

15   used in public reporting mechanisms such as

16   Monarch, where states are actually reporting

17   at the county level their PQI rates or PDI

18   rates to say what counties need to do more in

19   this particular area and do we need to drill

20   down and look at gastroenteritis, in this

21   county is particularly high. What do we need

22   to do? Do we need to look at rotovirus

1 vaccines for instance? Do we need to do

2 something else in the community?

3   If it's about asthma, do we need

4 to look at the treatment? Do we need to look

5 at the environment, some of the social

6 determinants.

7   So those are some instances where

8 it's being used at the county level. I will

9 tell within Monarch the developers, or the

10 people that are creating Monarch websites, are

11 actually wanting to go down to the zip code

12 level. There's some concern with that because

13 of the granularity and the small cell sizes.

14 So we aren't actually advocating that.

15   In terms of CMS. CMS has been,

16 I'll be honest with you, CMS is interested in

17 the PQIs. They are looking to AHRQ for

18 guidance on how to best use the PQIs for what

19 they are intended for.

20   So using them in the ACO programs

21 that are supposed to be comprehensive. Maybe

22 that makes sense. Again, we're looking at it

1   and we're looking at the reliability and

2   validity as they then can look at their

3   beneficiary population that are within the

4   ACOs.

5   May not be so appropriate for

6   physician groups. Right? Because of the

7   accountability issue that you're bringing up.

8   Again, it's about appropriate use. And AHRQ

9   being at the table to guide them.

10   As part of that conversation this

11   coming year AHRQ is undertaking an initiative

12   with all of its indicators to say what is the

13   appropriate use for this measure. It comes up

14   at every NQF meeting. And I feel that we need

15   some parameters around that discussion.

16   So we will be bringing in experts

17   to really put those parameters there. So it

18   is not everybody, this is not a free-for-all

19   grab whatever you want and use it however you

20   want. That's not the intent of these

21   measures.

22   MR. STOTO: I think, given all of

1   that, to me the issue is what does the

2   evidence that connects this outcome to the

3   quality of care received in the community?

4   So for something like diabetes I

5   think there's pretty strong evidence that if

6   you get good primary care you're less likely

7   to be admitted to the hospital for,

8   particularly emergent care, for instance.

9   I don't know. I haven't looked at

10   the question about this gastroenteritis,

11   whether that's through or not. I'm just

12   glancing at the materials put together it's

13   suggested that there's socioeconomic

14   differences, which is not at all the kind of

15   thing you'd be looking for. Is that fair?

16   MS. OWENS: Patrick, do you want

17   to answer that and then I'll give my two cents

18   based on an NIH study?

19   MR. ROMANO: Yes. I would say

20   that there's two strands of evidence. First

21   of all, there's absolutely no question that

22   all of the PQIs, including these pediatric

1 versions, are sensitive to socioeconomic

2 determinants. So clearly there's a

3 relationship between neighborhood household

4 income and other markers of STS and PQI rates.

5 So we know this.

6   But the two strands of evidence

7 relative to making it a performance measure

8 are, one, that I think there's very strong

9 evidence supporting oral rehydration as the

10 primary treatment for mild to moderate

11 dehydration presenting in really any clinical

12 setting, whether it's the physician's office

13 or an urgent care center or even a hospital

14 emergency department.

15   So with successful implementation

16 of oral rehydration hospitals around the world

17 have been able to demonstrate less use of

18 intravenous fluids and fewer hospital

19 admissions. So that's the one clinical

20 argument.

21   The second is sort of a construct

22 validity argument, which is the correlation

1 between PQI rates and primary care resources.

2 So in areas where there's a better supply of

3 family physicians and other primary care

4 physicians, primary care pediatricians, these

5 PQI rates tend to be lower.

6 And of course that may be somewhat

7 confounded with socioeconomic determinants but

8 nonetheless there are a couple of studies that

9 have adjusted for socioeconomic factors and

10 still shown that primary care access is

11 associated with lower PQI hospitalization

12 rates including dehydration and

13 gastroenteritis.

14 So those are the two major themes

15 in the literature that support this type of

16 indicator.

17 MR. MCINERNEY: So I've been in

18 practice for over 40 years and that was before

19 oral rehydration solutions were in vogue or

20 recommended in the gastroenteritis guidelines.

21 And certainly in our pediatric practice 30

22 years ago we admitted a lot more children for

1   intravenous rehydration with gastroenteritis.

2   But as we've been able to use oral

3   rehydration solutions the number of patients

4   that we've admitted has been vanishingly small

5   in the past ten years or so. So to me it is

6   a PQI or an ambulatory sensitive care

7   condition that the medical system or the

8   physicians and the primary care doctors in the

9   community have some control over. And so I

10   think in that respect it is worth measuring.

11   Certainly there are plenty of other

12   confounders.

13   The other point I think I would

14   make is that many people would say that an

15   ambulatory care organization ought to be

16   looking at the really big picture to improve

17   the health of the population for which they

18   are responsible. And community not-for-profit

19   hospitals are supposed to be trying to figure

20   out how to improve the health of the community

21   as a whole. And so, again, that would make

22   sense.

1   Now that being said, right now

2   there are really no pediatric ACL measures,

3   the ACL just applies for adults only. But if

4   we ever do get to some pediatric ACL measures

5   and recommendations from CMS this conceivably

6   would be a good one.

7   MR. STOTO: Ron and I are working

8   in Montgomery County on health improvement

9   activities and in fact this is, not this

10   particular one, but this family of measures is

11   something we're considering to use for exactly

12   that purpose.

13   MR. AUERBACH: I think that part

14   of what would make me feel comfortable, maybe

15   just making a recommendation, would be

16   understanding that in the release of the

17   recommendations or the approval process as we

18   go through this, if there is a mechanism for

19   doing what Katie was suggesting which is

20   distinguishing in the explanation of the

21   metrics between those that we think are

22   overwhelmingly measures of quality of care and

1   those where we think it's much more

2   complicated than that and also does involve

3   the strong consideration of the social

4   determinants of health.

5   The flip side of it is as I talk

6   to community health center docs is they don't

7   want to get blamed for poor quality when in

8   fact the patients they're treating are just at

9   higher risk and have a whole range of

10 different issues that just make it harder for

11 them to do simple things for families with

12 less socioeconomic problems, you know, are

13 able to do.

14   So just if there's -- That is a

15 heavy burden for you to distinguish between

16 those but I do think that, you know, if it's

17 possible to do that in a way so that the usage

18 can be clearer about when there are multiple

19 factors and it shouldn't be misinterpreted.

20   MS. BURSTIN: It's a very good

21 point. And just for those of you who are

22 relatively new to our process we do provide

1   all of that context from these discussions in

2   the report.

3   I also think it's important to

4   anchor on the fact of what the level of

5   analysis of this measure is. Nowhere does it

6   say -- And NQF is really pretty stringent

7   about measures at the intended level analysis

8   at which they have been tested.

9   So nowhere in this does it say

10   it's appropriate for a clinic or an individual

11   clinician's office. Or a hospital for that

12   matter. It is only higher levels of analysis,

13   which I think is why there was a comfort that

14   this did reflect a broader sense of systemic

15   care that frankly could potentially be very

16   useful to those within the community for

17   improvement. And potentially to be able to

18   benchmark yourself across communities.

19   But absolutely that, you know,

20   there's nothing in that level of analysis we

21   looked at, nothing there says clinic,

22   physician, clinician, hospital. It's really

1   only at those higher levels of analysis at

2   which this measure is intended.

3   MR. BIALEK: Helen, that was very

4   helpful. Thank you. And that raises another

5   question around this, as well as a number of

6   the other measures, which is the whole

7   stratification piece.

8   You know, if one is looking at the

9   county level metropolitan area, one looking at

10 the aggregate one won't make as much of an

11 impact necessarily as if one has some

12 stratification in there. And is that

13 something that AHRQ has considered with these

14 measures?

15   MS. OWENS: So in HQR and HDR you

16 can look at the breakout of the rates by race.

17 You can look at it by payer. And, when you

18 get to the adult measures, various age groups,

19 that kind of thing. You can look at it by

20 income. Or rural/urban, that would be

21 another. Although once you get to the county

22 level pretty, depending upon how that county

1   sits, it's kind of a moot point. Because it's

2   either all rural or all urban.

3   All that to be said is yes but

4   then that becomes at the reporting level.

5   That goes how do you then report his measure

6   out to make things comparable, right. So the

7   measure itself is not a stratified measure.

8   You could stratify it. It is only age and sex

9   adjusted. Okay?

10   MR. MCINERNEY: I think in my mind

11   a little bit of what Helen is talking about is

12   the difference between measurement for

13   improvement versus measurement for judgement.

14   And, you know, I think it would be helpful

15   over time to look at a measure like this and

16   find out, you know, are the number of

17   admissions for children with diarrhea or

18   dehydration increasing or decreasing over time

19   for a geographic area. And, you know,

20   hopefully they're decreasing.

21   Now then the question is well why.

22   And, you know, is it better medical care or is

1 it better social determinants of health. Well

2 that's something one might want to then try

3 and examine. But I think you'd like to know

4 at least is it getting better or worse.

5   You know, it's sort of you're

6 looking at your speedometer on your car and

7 going faster or slower then you could say well

8 all right, why. You know, what kind of road

9 am I on, is that why I'm going faster or

10 slower.

11   So I think in that respect it's

12 probably a worthwhile measure. And then you

13 can drill down after that.

14   This is a rich, rich discussion

15 because I think that this is something that's

16 important for not only the two pediatric

17 measures that we're going to consider but the

18 rest of the PQI measures that we're going to

19 be reviewing tomorrow. So I think it's

20 important to set the stage. And we should

21 have everybody have some input before we get

22 into the nitty-gritty of the measures.

1   So I see a couple more people

2   interested in saying a few more words.

3   Please.

4   MS. ASOMUGHA: I just want to make

5   sure that I'm understanding sort of the

6   universe of this measure. So what we're

7   looking at, it's not hospital. It's not a

8   measure of quality. But it's really about how

9   well we're treating gastroenteritis in the

10   community.

11   So whether somebody either in

12   their house is able to provide oral

13   rehydration because they've been educated

14   either by a clinician or a family member. Or

15   maybe it's the fact that they went to a

16   clinician or something and so they never got

17   to the hospital. But that's what we're

18   looking at is --

19   MALE PARTICIPANT: Or avoided the

20   problem in the first place.

21   MS. ASOMUGHA: Altogether. Yes.

22   So they washed their hands and it was never --

1   Right. Right. Am I right in thinking --

2   Okay. Just want to make sure.

3   MS. LUCK: I can imagine a

4   scenario in which the community's ability to

5   prevent hospitalization remains exactly the

6   same and rates go up or down because of other

7   social determinants of health, for example

8   changes in water qualities.

9   And that's going back to what John

10 said which is when you define it as a measure

11 of health system performance, well then now

12 we're holding the health sector responsible

13 for water quality, which may be where we need

14 to go but we need to keep that in mind.

15   MR. VENKATESH: I guess sort of

16 related to than and what Tom just said is that

17 I can see a lot of use for this measure from

18 a perspective of within area improvement. So

19 seeing how you're doing over time and the area

20 can decide whether it's being driven by water

21 quality, whether it's driven by the structure

22 of ambulatory care, things like that.

1   I guess my question is for these

2   measures, is what's the threshold for how

3   valid they need to be to be compared between

4   or across the areas for endorsement? Because

5   I could see this being something that makes

6   sense, could be endorsed, can be used and a

7   county could re-use and repeated measurement.

8   Where I kind of struggle with it a

9   little bit more, in comparison to even some of

10   the other ones, is what's the meaning of this

11   measure's score in comparison to other

12   counties? And how much do I get hung up on

13   that when we think about the validity of the

14   measure?

15   MS. ASOMUGHA: And I'll just add

16   something to what Arjun said, that's exactly

17   it. So I don't think personally after reading

18   and hearing the discussion that you would want

19   to make it comparable across communities only

20   because the drivers for whatever the rates or

21   the score is could be very different across

22   communities.

1   And you'd want to be able to say,

2   as an individual community or metropolitan

3   area or whatnot, that okay these were the

4   issues that were potentially driving this and

5   that might not look the same as, you know,

6   Orange County and Los Angeles County in

7   southern California.

8   MR. MCINERNEY: We get to say

9   that. But I'm just the just Chair.

10   MS. OWENS: So I guess my question

11   would be --

12   MR. SALIVE: These measures are

13   fine. And I think is CDC is done we would be

14   all in favor of that for, you know, comparing.

15   And if you publish a map, everyone's

16   publishing maps these days, you know, it's

17   not, I mean, no one wants to be that one with

18   the dark red. But there are, you know, it

19   raises a issue and so I think we have to look

20   at this with these criteria we have and not

21   get all bent out of shape by how it might be

22   used.

1   I mean, these are existing

2   measures. They're in use, right? So I mean

3   that is reported in here, who's using it. I

4   went in on the one I had and who's using it,

5   you know, it's reported. The maps are out

6   there on the diabetes measures. They are

7   published every year. So the genie is out of

8   the bottle.

9   MR. AUERBACH: I hear folks saying

10   use the data but don't misinterpret it. But

11   I would just say pay real good attention to

12   what's in writing. Because the writing

13   sometimes does say this is about the

14   healthcare system. I mean, I'm just looking

15   at this measure as written and it says it is

16   a measure of experiencing better management of

17   acute gastroenteritis. That's what it's

18   measuring.

19   And I think that there was similar

20   language in the justification that it was not

21   attributable to hospitals, attributable to

22   care and the community.

1   So we just have to -- We shouldn't

2   say hey this really isn't a measure of quality

3   but then we have some language in there that

4   I think it would lead folks that are trying to

5   do that to interpret it in a certain way. We

6   just have to go through and edit it carefully

7   I think so it says the right things.

8   MR. MCINERNEY: Okay. Well it is

9   almost 4:45. And if you look at our agenda we

10   have NQF member and public comment at 4:45.

11   And I've been informed Adeela that we really

12   should open it up for that. Obviously that

13   would be for the dental measures only, since

14   we haven't done any other measures.

15   And I think we should do that and

16   then probably we'll just have to really,

17   overnight get ourselves ready and gird our

18   loins to do all of the PQI measures tomorrow.

19   I suspect some folks are going to have flights

20   that they need to catch and we can't stay

21   until 5 o'clock tomorrow since we're

22   supposedly going to adjourn at 3:00.

1   So I think let's go ahead and

2   we'll open it up for the public comment then

3   we'll get to the measures tomorrow.

4   OPERATOR: If you want to make a

5   public comment please press star then the

6   number one.

7   There are no public comments at

8   this time.

9   MR. MCINERNEY: Do we want to,

10   since we have another 15 minutes or so before

11   we're ready to adjourn, do we want to try and

12   tackle that first measure, the gastroenteritis

13   measure on Page 37?

14   All right. Let's go ahead and do

15   that. And I don't know, who wants to discuss

16   that? Michael or Jacqueline?

17   MS. KHAN: Oh there's a mistake

18   actually.

19   MR. MCINERNEY: Oh.

20   MS. KHAN: It's 727, it's Amy and

21   Tom.

22   MR. MCINERNEY: Oh, Amy. Please.

1   MS. MINNICH: After all this

2   discussion I don't know about this, we'll give

3   it a try.

4   So just to recap, this measure is

5   for gastroenteritis admission rate. The

6   numerator statement is, "Discharges from age

7   3 months to 17 years with a principle

8   diagnosis of gastroenteritis or a secondary

9   diagnosis of gastroenteritis with a principle

10   diagnosis code dehydration."

11   Denominator statement is,

12   "Population 3 months through 17 years in a

13   metropolitan area or county."

14   The level of analysis, as we've

15   already said, is by county or city. And

16   population national, regional population or

17   state.

18   As far as the evidence, this is

19   purely an outcome measure so there is no

20   further discussion on that. The author

21   actually did demonstrate significant, there

22   were six randomized trials that were reported.

1   And so there was strong evidence on this

2   measure. Do you have any questions?

3   MR. MCINERNEY: Mike.

4   MR. STOTO: Yes. I understand

5   that the general rule that outcome measures

6   don't, you know, don't need to cite the

7   evidence. But for this kind this strikes as

8   one where it really would be helpful to know.

9   And that's what the question I was asking

10 about and Patrick kind of answered. And there

11 is a bit in here that I've found about that.

12   And really the question is to what

13 degree does this reflect variation that can be

14 attributed to the health system broadly

15 defined or is it just socioeconomic

16 differences?

17   And I guess what I hear is that

18 there's some evidence of that but that it's

19 more than just socioeconomic. Is that

20 correct? Yes.

21   MR. MCINERNEY: Any other comments

22 on the evidence criteria?

1   MR. FRANCE: I would probably just

2   point out that the precipitous drop in this

3   rate over the last seven or eight years

4   probably suggests that it's not socioeconomic,

5   but it's care delivery systems and new

6   vaccines that's driving that.

7   MR. MCINERNEY: I think that's a

8   reasonable assumption since we know that

9   childhood poverty has remained level over the

10   past 20 years. So we probably can attribute

11   it to that.

12   Okay. So let's vote on the first

13   measure. And could we go ahead and do that?

14   Thanks.

15   MS. ROBINSON-ECTOR: For evidence,

16   1 is yes and 2 is no. Voting is open.

17   Okay. We're still waiting for one

18   vote. All votes are in and voting is now

19   closed. For evidence we have 21 votes for yes

20   and 1 vote for no.

21   MR. MCINERNEY: Okay. Performance

22   gap.

1   MS. MINNICH: So looking at the

2   opportunities for improvement -- I'm sorry.

3   Opportunities for improvement,

4   there are actually two specific things that

5   were noted. One was of disparities and lower

6   economic zip codes. And secondly a

7   performance gap looking at variation across

8   providers. So those were the two areas that

9   our group concluded.

10   MR. MCINERNEY: Any other

11   discussion on performance gap? Okay, let's

12   vote please.

13   MR. STOTO: Some of that evidence

14   is really pretty low. Or pretty old I should

15   say. '92, '88. Yes.

16   MR. MCINERNEY: Okay.

17   MR. ROMANO: Well, could I address

18   that?

19   MR. MCINERNEY: Sure.

20   MR. ROMANO: I think that more

21   recent analysis have actually shown that these

22   disparities unfortunately have increased.

1 This has been tracked in the national

2 healthcare disparities report and elsewhere.

3   So, for example, the ratio between

4 the lowest income and the highest income

5 communities has actually risen from 1.48 to

6 1.64 even while the overall rate has dropped

7 by 2/3rds since 2005.

8   And similarly the ratio between

9 rural and urban communities has risen from

10 about 2 to about 2.5, 2.46. So rural

11 communities, the kids are nearly 2-1/2 times

12 more likely to be hospitalized. So if

13 anything the disparities have actually

14 increased during this time while the overall

15 rates have decreased.

16   That's from 2011 data compared

17 with 2005.

18   MR. STOTO: It would be good if

19 the record actually reflected that. That's --

20   MR. MCINERNEY: Thank you for that

21 information.

22   MR. CARILLO: But the rates of

1 decrease, are they different from one to the

2 other? Very often you see that there's a

3 decrease and the decrease is quite large for

4 the better off community than the other. So

5 you still have a --

6   MR. ROMANO: Right --

7   MR. CARILLO: -- disparity gap.

8   MR. ROMANO: -- the disparities

9 have widened in relative terms. So the rates

10 have dropped faster for higher income

11 communities and for urban communities and

12 western communities and communities with a

13 high supply of primary care physicians

14 compared with the alternatives.

15   Does that makes sense?

16   MR. CARILLO: A complicated topic.

17   MS. OWENS: To Michael's point,

18 I'm under the impression I can update the

19 forms, correct? To put more recent data in

20 there.

21   MR. MCINERNEY: Okay. Well let's

22 vote on the performance gap please.

1   MS. ROBINSON-ECTOR: For

2   performance gap, 1 is high, 2 is moderate, 3

3   is low and 4 is insufficient. And voting is

4   now open.

5   All votes are in and voting is now

6   closed. For performance gap, 13 voted high,

7   8 voted moderate, 1 voted low and 0 voted

8   insufficient.

9   MR. MCINERNEY: Okay. Priority.

10   MS. MINNICH: So under the

11   priority section the workgroup did feel that

12   there was significant priority and that one

13   out of every 50 children experienced an acute

14   stay related to GI care. And there was still

15   high utilization for hospital versus

16   outpatient management.

17   MR. MCINERNEY: Further

18   discussion? Okay. Let's vote please.

19   Thanks.

20   MS. ROBINSON-ECTOR: For high

21   priority, 1 is high, 2 is moderate, 3 is low

22   and 4 is insufficient. And voting is now

1   open.

2   I think we're just waiting for one

3   vote.

4   All votes are in and voting is now

5   closed. For priority, 15 voted high, 7 voted

6   moderate, 0 voted low and 0 voted

7   insufficient.

8   MR. MCINERNEY: Okay. We'll now

9   move to scientific acceptability.

10   MS. MINNICH: So looking at the

11   statements again. The numerator statement, 3

12   months to 17 years with ICD-9 code of

13   gastroenteritis or as secondary diagnosis of

14   gastroenteritis with a principle diagnosis of

15   dehydration excluding pregnancy and OB related

16   cases, transfer from other institutions, age

17   less than or equal to 90 days and any

18   diagnosis code of gastroenteritis

19   abnormalities or bacterial gastroenteritis.

20   Denominator statement simply

21   looking at the population age, 3 months to 17

22   years in a metropolitan area. Exclusions were

1 not applicable. The data source was purely

2 administrative claims so there were no

3 concerns related to multi-source data.

4   MR. MCINERNEY: Any comments on

5 the reliability measure? Okay, let's vote --

6 Oh, sorry. Go ahead, Ron.

7   MR. BIALEK: There was a comment

8 submitted about, let's see from J.H.M.

9 Armstrong Institute. And I'm just wondering

10 if you can respond to that?

11   This was about the due to

12 stratification of data calculation processes,

13 datasets are poor quality, e.g., missing

14 patient-level data elements such as gender,

15 age, discharge, et cetera. Am I reading from

16 the wrong?

17   MS. OWENS: Okay. So I think it's

18 a misunderstanding of the age group data,

19 because it's actually not missing these data

20 elements. Particularly gender and age or

21 discharge status, principal and secondary

22 condition.

1   I'll go back and look at it but I

2   think it's a misunderstanding.

3   MS. ASOMUGHA: The comment wasn't

4   saying that the data is excluded. It's just

5   noting that they are excluded. And that if

6   the state agencies or vendors don't enforce

7   data quality standards there could be

8   differences in the communities that may be

9   reflective of poor hospital coding and

10   associated records being excluded from

11   analysis.

12   So they're wondering about the

13   quality of data from the hospitals.

14   MS. OWENS: So to that point I

15   think more of the concern would not be coming

16   of the hospital per se but may be coming out

17   of one of the programs of the programs of the

18   community level if they have incomplete data.

19   And as with all measures you have incomplete

20   data, you will have an incomplete measure.

21   Then you work with whoever's giving you the

22   data to get complete data so that you can

1   actually populate it.

2   So I think it's a function of

3   who's putting the data in rather than the data

4   it's tested on.

5   MR. MCINERNEY: Okay. Let's vote

6   on the reliability please.

7   MS. ROBINSON-ECTOR: For

8   reliability 1 is high, 2 is moderate, 3 is low

9   and 4 is insufficient. And voting is now

10   open.

11   All of the votes are in and voting

12   is now closed.

13   For reliability 17 voted high, 5

14   voted moderate, 0 voted low and 0 voted

15   insufficient.

16   MR. MCINERNEY: Good. Okay.

17   Validity please.

18   MS. MINNICH: There were two

19   comments specifically referencing around

20   validity testing. One was the impact of the

21   vaccine, the rotovirus vaccine, versus the

22   decreased PCP access and oral administration

1   of hydration.

2   Second was something that we

3   talked about earlier, was just looking at the

4   insurance clarity around 24 hour admissions as

5   compared to observation status.

6   MR. MCINERNEY: Any further

7   discussions on validity? Yes?

8   MR. FRANCE: Arjun pointed out that

9   in certain counties you might have this bias

10   if your hospitals in this county and the

11   neighboring counties don't have the same

12   hospitals. Is that a very common occurrence

13   across all counties as you look at the data?

14   MS. OWENS: Well it doesn't matter

15   which county the hospital is in because you're

16   looking at hospitalizations as it's got the

17   patient residence in it.

18   MR. FRANCE: Patient residence.

19   Okay. Thank you.

20   MS. OWENS: So it's a little

21   different.

22   MR. FRANCE: All right. Thanks.

1   MR. MCINERNEY: Okay. Shall we

2   vote please.

3   MS. ROBINSON-ECTOR: For validity,

4   1 is high, 2 is moderate, 3 is low and 4 is

5   insufficient. And voting is now open.

6   All of the votes are in and voting

7   is now closed.

8   For validity, 13 voted high, 8

9   voted moderate, 1 voted low and 0 voted

10   insufficient.

11   MS. MINNICH: The feasibility

12   there were not specific concerns noted as

13   there was, it's just purely a claims

14   administration data source.

15   MR. MCINERNEY: Any discussion on

16   feasibility? All right. Moving right along,

17   we'll vote on that.

18   MS. ROBINSON-ECTOR: For

19   feasibility 1 is high, 2 is moderate, 3 is low

20   and 4 is insufficient. And voting is now

21   open.

22   Okay. All of the votes are in and

1 voting is now closed.

2   For feasibility, 20 voted high and

3 2 voted moderate, 0 voted low and 0 voted

4 insufficient.

5   MS. MINNICH: And finally on

6 usability, three states are currently

7 reporting this data including Connecticut, New

8 York and California. The measure is already

9 in use and there has been significant

10 improvement over time. From 2007 the rate was

11 121.5 per 100,000 as compared to 2011 where it

12 was reduced to 67.5 per 100,000.

13   MR. MCINERNEY: Comments on

14 usability. All right. Let's vote please.

15   MS. ROBINSON-ECTOR: For

16 usability, 1 is high, 2 is moderate, 3 is low

17 and 4 is insufficient information. Voting is

18 now open. We're still waiting on one vote.

19   All of the votes are in and voting

20 is now closed.

21   For usability, 17 voted high, 5

22 voted moderate, 0 voted low and 0 voted

1   insufficient information.

2   MR. MCINERNEY: Okay. We now have

3   overall suitability or endorsement. Any

4   discussion about that? Yes?

5   MS. MOLINE: My only comment is on

6   reading this is I think it's a misnomer to

7   just call it gastroenteritis because bacterial

8   gastroenteritis is excluded from this measure.

9   So it's really looking purely at viral

10   gastroenteritis so that's what it should be

11   called. Because if you're looking at the

12   measure and you're thinking by county then

13   there can be outbreaks by county that are

14   related to bacterial whatever and you're going

15   to look at it and say oh this is the whole

16   spectrum if you don't dig down deeper. So I

17   think I would recommend that it be modified.

18   MR. VENKATESH: My only concern is

19   I don't know if the fidelity of codes are good

20   enough to make the distinction. Because the

21   vast majority of gastroenteritis may not have

22   an etiology applied to it. So there are codes

1   that exist for just gastroenteritis. And so

2   there are probably many bacterial

3   gastroenteritis that have a course under the

4   viral ones and that may not actually be

5   excluded from the measure and still be in it.

6   I think it's fine. I think it still is a good

7   measure, it does everything good and fine.

8   But I'm not sure that we can call everybody in

9   the measure a bacterial.

10   MS. MOLINE: I was just doing it

11   based on what the specific exclusion are. So

12   when you're looking at what the criteria were

13   as defined it was excluding every type of

14   bacteria.

15   MS. OWENS: Well we hear what

16   you're saying. So something, maybe it's

17   gastroenteritis excluding bacterial admission

18   rate. You know, working with what you're

19   saying I agree with you, Arjun, in terms of

20   the coding because gastroenteritis is not

21   elsewhere classified or specified is a general

22   code and you don't know the etiology.

1   MR. MCINERNEY: Any further

2   discussion? Okay. Let's vote please.

3   MS. KHAN: I can read it. So

4   we're voting on overall suitability for

5   endorsement. Does the measure meet NQF

6   criteria for endorsement? 1 is yes and 2 is

7   no. Want to press the button Katelynn? I

8   think we're one short.

9   So we have 22 votes for yes and 0

10 for no. So the Measure 727 gastroenteritis

11 admission rate is recommended.

12   MR. MCINERNEY: Thank you

13 everybody for working hard late in the day and

14 getting through at least this one measure. I

15 think we'll not press our luck and go on any

16 further. And we'll all have a nice, hopefully

17 have a good night's rest and be ready to go

18 and finish up the -- I think we have still

19 eight measures to go so we're pretty much

20 halfway through our, if I counted correctly.

21   MS. KHAN: Yes, we're about

22 halfway through.

1   MR. MCINERNEY: Halfway through.

2   So good job everybody today. Any comments or

3   housekeeping measures for tonight?

4   MS. KHAN: Yes, this is just a

5   quick summary of what we did today. I haven't

6   added in the two, the recommended for the PDI

7   but it's been recommended. 2508 has been

8   recommended. 2509 has been recommended. 2528

9   and 2511 have been recommended. And the

10   Committee has decided to delay a vote on 2517

11   and 2518 until after public and member

12   comment.

13   We did reserve dinner for

14   everybody. The restaurant information is up

15   there. The reservation is for 6:30.

16   Just quickly, housekeeping, all of

17   you will have separate checks and NQF does

18   reimburse for dinner up to $36. So the staff

19   will be there as well so we hope to see you

20   there. And I'll keep this up so you can copy

21   the address down.

22   And, sorry. Just one last

1 reminder, breakfast is at 8:30 tomorrow and

2 we'll be starting evaluation at 9:00. So

3 we'll see you at 9:00.

4   (Whereupon, the meeting in the

5 above-entitled matter was concluded at 5:06

6 p.m.)

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

A

$36 409:18
a.m 1:9 5:2 72:20
  72:21 154:9,10
AAP 93:9 230:5
AAPD 317:11,16
  318:3
ability 131:12
  203:8 229:11
  275:18 302:12
  386:4
able 21:10 24:9
  27:8 28:20 29:13
  29:14 30:9 74:3
  75:17 80:11 85:20
  86:10 95:1 119:2
  119:9 121:4 144:4
  166:5 176:1
  188:11 197:9
  220:5 221:6
  227:13 231:7
  254:9 289:18
  293:4,9 304:11
  307:18 310:16
  376:17 378:2
  380:13 381:17
  385:12 388:1
abnormalities
  346:20 399:19
above-entitled
  345:8 410:5
abscess 292:6
absence 45:5 135:1
  298:11
absolutely 86:4,20
  92:10,20 93:22
  113:10 171:13
  178:14 197:16
  290:7 375:21
  381:19
abstain 156:20
  169:9
abstaining 156:15
ACA 77:20 115:6
Academy 8:22
  122:14 317:8
accept 303:6

acceptability 27:11
  38:17 167:3
  185:18 186:14
  187:19 193:1
  246:12 399:9
acceptable 264:17
access 6:9 34:9
  75:12 90:2 141:9
  141:12,13 144:22
  145:11 196:15
  209:4 260:2,22,22
  262:15 267:18
  275:10,11,11,13
  275:19 281:9
  284:14 285:16
  288:1,7 300:16,18
  305:1,17 307:3
  322:10 323:5,14
  323:16,20 324:22
  326:7 329:6
  347:14 355:14
  357:12 368:6
  369:1 372:10
  377:10 402:22
accessed 348:2
accesses 141:6
accommodate
  219:12
accompany 136:7
  136:13
accomplish 58:16
  60:2 67:1
accord 235:7
account 34:8
  112:17 177:13
  193:12 266:1
accountability
  43:14 45:1,4,5,12
  45:20 46:8,9,15
  143:9 144:8 153:6
  158:4 159:22
  160:1 199:12,13
  220:2 374:7
accountable 46:4
  51:20 111:18,19
  112:5 213:4,5
  252:17 256:13

  298:10 362:20
  364:19 365:12
accounted 235:2
Accreditation
  61:14
accuracy 333:11
accurate 101:17
  105:9
accurately 74:13
achieve 22:17
  59:18 312:8
achieved 60:6,7
achieving 28:19
ACL 379:2,3,4
ACO 373:20
ACOs 374:4
Act 49:12
action 3:14 41:21
  47:20 48:11 60:22
  61:11 67:18
actionable 370:22
  371:6
actions 115:19
activities 7:11 13:8
  17:6 31:22 32:9
  59:9 61:19 65:12
  67:13 266:21
  379:9
activity 7:20 53:10
  261:7
Acts 107:14
actual 125:2,4
  135:13 294:12
  346:6
acute 347:18
  389:17 398:13
ADA 78:8 97:1,2
  100:16 122:15
  211:1 222:3
  225:22
add 9:14 29:16
  41:9,10 44:12
  67:17 71:13 89:15
  92:9 98:3 108:18
  109:17 115:8
  116:20 119:6
  131:20 132:11

  139:14 143:3
  166:8 168:1
  173:10 195:12
  197:21 203:7
  212:21 213:22
  214:4 215:19
  219:10 221:9
  224:2 229:19
  250:21 261:12,18
  270:20 286:7
  291:9 312:17
  316:5 328:11
  345:14 349:17
  359:4,22 364:13
  387:15
added 80:22
  189:21 409:6
adding 110:20
addition 289:20
  291:8
additional 25:16
  39:3 61:9 74:3
  80:22 106:1
  155:10 181:13
  249:2,19 290:13
  291:13 302:18
  334:5 341:15
address 28:18,21
  33:18 35:4 37:5
  41:18 55:9 73:21
  75:8 95:20 106:3
  110:17 111:16
  158:7 276:9 327:5
  341:2 353:9
  395:17 409:21
addressed 101:13
  103:2,19 104:2
  105:18 142:22
  175:4 192:4
  305:13 327:10
addresses 185:4
  323:22 354:4
addressing 38:4,6
  89:8 123:15 305:9
  362:20
Adeela 2:8 3:9 6:20
  28:4 39:16 40:5

  188:13 206:3
  390:11
Adella 28:5
adequate 146:8
  150:14 191:3
  192:3
adjacent 367:14
adjourn 4:22
  390:22 391:11
adjudicated 349:8
adjust 255:19
adjusted 320:16
  377:9 383:9
adjustment 150:16
adjustment/strat...
  192:5
administer 143:22
  253:22 254:3
administration
  253:6 281:19
  402:22 404:14
administrative
  103:8 105:7
  135:11 266:20
  332:21 333:17
  341:9 400:2
administrator
  144:15
admirable 64:6
admission 3:17
  71:20 346:12
  352:5,11,18
  353:11,12 356:7
  367:16 392:5
  407:17 408:11
admissions 346:14
  346:21 376:19
  383:17 403:4
admit 354:22
admitted 353:19
  356:5 361:14
  375:7 377:22
  378:4
adolescent's 97:6
adolescents 217:4
adopt 32:6 268:12
adopted 216:15

282:4
adopting 201:12
adult 114:3,8
283:15,17 382:18
adulthood 218:15
adults 283:13
379:3
advance 76:15
167:19
advanced 83:1
advantage 201:16
212:11
advent 77:20
adverse 370:6
advice 201:11
advised 301:20
Advisor 12:22
Advisory 17:19
33:8
advocating 203:18
373:14
affect 215:15
affectionately
29:21
affordability 57:8
affordable 30:20
49:12
afternoon 207:12
236:3 249:1
345:12,22 347:4
age 85:3 86:3 92:18
92:18 93:12,16
97:3,17 98:21
101:3 176:12
190:13 208:3
215:12,13,17
216:14,22 217:1,3
217:6,8 218:5,12
219:1,2,8,14,16
219:20 220:10,13
221:10 222:4,17
222:20 224:4,10
224:20 225:16
226:5,9,10 227:1
227:8,15,19
228:17 229:9
230:1,22,22 231:3

231:9 236:11
237:5,6,14,18,19
237:20,21 238:7,8
238:15,19 240:20
254:18 256:1,16
280:4 286:19
294:21,21 315:14
329:9 332:3
366:11 382:18
383:8 392:6
399:16,21 400:15
400:18,20
agencies 61:15
78:12 401:6
agency 52:21
agenda 68:19 72:9
390:9
agendas 25:11
ages 86:22 98:10
266:3 293:20
346:17 366:10
aggregate 151:18
216:19 227:8,11
227:18 228:4,9,14
253:10 256:11
382:10
aggregated 245:22
Aging 2:1 12:8
ago 7:9 76:19 92:6
153:22 207:4
279:5 280:1 314:6
377:22
agree 123:20
173:17 291:16
298:9 301:9
329:20 344:9
370:20 407:19
agreed 46:13,18
59:8 88:22 151:15
agreement 26:4
169:20 195:18
240:17 287:20
318:10 333:15
334:1
ahead 72:9,9 73:1
73:13 88:3 90:17
91:2 106:20

116:12 123:14
128:19 139:15
140:22 152:20
153:2 155:9,15
158:9 162:21
174:1 176:5 180:2
187:3,19 200:9
256:6 277:21
339:3 344:4 391:1
391:14 394:13
400:6
AHIP 78:14
AHRQ 2:14,15
3:18 37:5 43:17
57:17 72:7 345:17
345:20 352:13
373:17 374:8,11
382:13
AIDS 36:2
aim 30:17 48:18
air 33:22 192:22
algorithm 134:21
147:1,9,16 148:5
148:22 172:19
174:7 175:5 183:2
302:3,21
algorithms 169:16
171:15,16 207:6
297:12 352:13
align 56:3 63:15
154:13
aligned 32:4 34:4
48:17 62:5
aligning 11:9 36:10
alignment 57:7
64:6 66:13
aligns 61:18 86:22
Allen 2:9 3:15 29:5
41:19 44:8 47:16
47:17 68:6,13,17
alliance 2:12,13,13
4:5,8,11,13,15,18
72:12 73:7 74:12
88:20 208:12
allotted 25:15
allow 26:3 132:11
140:13 188:2

202:13 237:10
306:15
allowed 81:16
109:6,14,15 240:8
282:3
allows 47:3 349:21
alternative 195:2
215:6
alternatives 397:14
Altogether 385:21
AMA 78:14
ambiguous 147:22
ambulatory 210:4
347:12 350:19
378:6,15 386:22
amenable 350:19
amendment 104:13
American 1:17
8:22 13:20 17:7
67:6 96:19 122:14
317:7
AmeriHealth 1:14
10:6
Amgen 2:2 13:6,10
amount 118:21
207:7 289:19
amounts 91:20
228:21
Amy 1:21 10:16
391:20,22
analogous 93:15
analogy 284:18
304:21
analysis 21:5 36:20
50:5 129:1 207:4
219:13 223:14
253:16 301:12
366:6 381:5,7,12
381:20 382:1
392:14 395:21
401:11
Analyst 6:22
analytics 7:2
analyze 229:12
anchor 381:4
and/or 35:3 128:4
160:7 184:4

Angeles 388:6
angle 302:7
Ann 2:8 3:6 5:10
7:5 19:15
announce 9:18
125:18 319:16
announced 162:13
announcing 126:2
163:13
annual 38:11 83:16
139:20 277:3
280:2,9 284:3,4
329:6
answer 6:16 89:13
100:2 129:14
131:11 260:8
288:4 297:16
346:9 375:17
answered 110:21
110:22 165:14
272:15 297:19
365:14 393:10
answers 145:19
203:4
anti 94:5
anxiety 200:13
anybody 103:22
105:22 116:17
160:18 180:4
181:14 186:7
192:22 371:17
anymore 91:15
116:7
anyone's 315:6
anything's 43:6
anyway 206:20
apologize 37:15
119:17 274:6
277:22 319:4
325:5
appeal 41:5,7
appeals 27:2
appear 126:11
appendix 106:14
338:5
applicable 78:20
79:4 102:22 189:4

189:10 218:11
332:11 400:1
application 48:8
51:9 62:9 209:13
213:17 219:3
321:7,9,21 322:1
applications 49:11
62:16 208:5
209:10,15,18
213:12 220:21
222:2 223:8
applied 98:12
106:7 107:5,7
132:8 136:9
141:16 172:6
189:11 231:18
257:8 281:20
329:21 406:22
applies 44:17 107:9
110:6 212:4
224:21 379:3
apply 51:2,14
77:17 103:10
110:7 130:15,15
141:12 149:14,21
194:5 211:7,15
274:10,13 309:2
332:22 356:22
applying 171:18
209:6 210:7
212:18
appointment
112:11
appreciate 163:12
167:18
approach 80:14
84:3 88:13 122:21
227:7 257:20
appropriate 11:14
11:17 101:8 146:8
150:14 191:2
192:2 261:11
280:17 347:22
374:5,8,13 381:10
appropriateness
164:7
approval 23:5 27:1

302:8 379:17
approve 371:21
approved 27:4
271:1 358:9
approximately
9:10
April 1:6 40:10,11
ARAVAMUDH...
73:15 76:3 84:5
95:6
Aravamudhan
2:12 73:9 106:10
106:20 107:11
109:17 111:5,9
117:9,18,21
129:13 131:19
139:13,16 141:17
144:14 176:9
187:4 190:12
194:4 195:11
196:21 197:4,10
199:7 200:18,22
201:8,16 203:6
208:14 210:8
212:21 215:18
220:11 224:1
225:1 229:18
231:12 239:11
242:7,13,21
247:19 255:20
259:15 270:5
276:1 277:18
283:4 284:4 285:9
295:2 302:11
320:12 321:3,8,20
322:2 325:12
327:11 330:4
335:18,22 336:20
337:1 338:21
340:8,13,22 341:6
344:9 345:4
area 20:11 21:1,14
41:17 47:7 62:22
77:13 98:22 100:4
106:3 128:17
165:9 185:18
233:5 234:13

238:22 366:12,14
366:15,17 367:2
369:19 372:19
382:9 383:19
386:18,19 388:3
392:13 399:22
areas 3:12 28:21
50:6 51:1 53:1,18
53:19 54:2 60:8
63:4 65:19 100:5
139:4 174:13
185:21 190:17
377:2 387:4 395:8
arena 355:3
argument 376:20
376:22
arguments 260:21
Argun 17:3
Arjun 2:4 121:15
170:5 247:16
320:17 387:16
403:8 407:19
Armstrong 400:9
arraignments
291:19
arrange 301:8
arrangement 79:16
79:18 82:20
arrangements
178:1
array 101:16 336:3
arrived 325:10
article 222:4
articles 222:13
artificial 253:11
Ashley 6:22
aside 237:20
asked 7:10 24:13
78:9 168:16
177:14 178:4
243:8 273:16
323:10,17 340:6
340:15
asking 23:19
104:14 143:18
148:5 152:3
168:11 179:18

229:14 289:20
324:18 358:7
393:9
asks 133:4 213:17
Asomugha 1:13
12:20,21 123:1,5
200:12,21 201:5
201:15 202:2
261:13,17 324:14
364:13 365:9
385:4,21 387:15
401:3
aspect 123:17
185:6 229:7
assess 33:21 35:3
197:9 213:9
347:14
assessed 103:14
287:13 290:20
333:8
assessing 27:16
31:21 93:11
122:22 149:18
263:15
assessment 52:6
59:1 66:10,19
75:20 86:6,18
113:13 117:22
118:2,3,11 122:8
122:10 133:5
134:18 135:10
136:7,12 138:4
141:5 155:8,21
161:20 178:9
198:9 204:11
230:5,6,7 271:19
290:9 298:5 302:6
316:10
asset 59:1 62:3 90:7
assigned 36:1,3,7
38:3 70:19 99:17
129:5
associate 9:4 18:5
132:10
associated 172:5
377:11 401:10
Association 1:17

2:1 13:21 15:5,13
79:6 96:19
Association's 67:7
assume 200:15
273:6 362:9
assumed 282:10
assuming 226:15
274:18
assumption 134:13
394:8
assumptions
290:17
asthma 373:3
attempted 354:1
attend 25:22
attendance 167:18
attending 41:2
attention 5:15 6:13
71:9 89:11 171:15
177:3 255:11,17
294:16 389:11
attributable 369:15
389:21,21
attribute 394:10
attributed 393:14
attributing 357:16
attribution 110:8
355:1 358:19
audience 154:21
audience-specific
59:19
audiences 158:2
Auerbach 1:14
14:9 37:14,15
62:7 64:3 107:21
111:2,6 164:2,10
164:13,17 215:11
217:10 236:10
254:15 356:19
357:13,20 362:6
379:13 389:9
Auerback 14:10
August 40:15,18
author 392:20
authorizing 82:22
authors 103:6
332:19

bottle 389:8
bottled 91:19,20
bottom 12:5 35:19
    124:15 147:10
boundaries 52:17
boundary 219:6
box 148:4 182:12
    182:14,15,17
    183:4 203:10,12
brand 238:1
break 71:2,3 72:16
    73:4 154:1,7
    176:17 205:14
    206:1,2 218:8
    269:8,10,12
    282:15 344:15,16
    344:18 345:2
breakfast 410:1
breakout 382:16
breaks 6:4 26:1
breast 37:9
brief 73:4 176:7,10
    208:1 218:7
    269:20 350:4
briefly 22:21 23:19
    77:11 105:22
Bright 88:5,11
    230:3,8 295:8,12
bring 5:14 19:7
    33:17 36:5 57:4
    67:14 68:21 70:20
    74:13 80:11 100:9
    101:7 104:1 116:8
    171:17 174:17
    175:12 186:12
    219:7 245:9,12
    300:7 338:2
    350:10 368:1
bringing 56:19,22
    99:18 290:8 326:5
    374:7,16
brings 25:5 194:17
    222:20
broad 53:13 75:21
    78:9,15 215:13
    216:22 218:5,11
    346:2 347:3

371:12,13 372:13
broaden 65:7 90:9
broader 33:13
    44:10 46:17 48:12
    64:14 80:10 92:11
    339:17 359:13,17
    381:14
broadly 14:19 51:8
    52:9,21 56:5
    60:10,12 63:15
    77:5,17 240:1
    393:14
brought 42:5 49:17
    59:21 104:3,5
    120:18 165:19
    178:12 193:5,8
    247:2 289:15
    350:22
build 80:4 341:10
building 76:19
    219:15 340:2
built 21:21 33:22
    133:18 141:22
    326:3
bulleted 107:6
bump 195:14
bumping 238:4
burden 213:13
    220:9 342:20
    343:7 380:15
Burstin 2:7 19:18
    19:20 29:16 43:5
    45:16 46:20
    240:12 380:20
business 92:4
    341:11
button 124:14,15
    124:18 146:10,11
    146:12,13 408:7
buttons 145:19,21
buttressed 88:13

_____
        C
_____
c 152:12,14 158:15
    169:2
C-O-N-T-E-N-T-S
    3:1 4:1

calculate 367:20
calculated 334:3
    367:18
calculating 367:20
calculation 400:12
calendar 187:13
California 114:8
    115:4 122:11
    388:7 405:8
call 6:15,16 26:8,9
    26:18 39:2 40:14
    58:6 65:16 67:20
    67:22 68:4 92:16
    93:14 97:21 98:3
    101:6 103:21
    104:4,6,15 120:1
    134:20 152:2
    171:14 177:3
    179:9 275:11
    324:5 327:7
    340:19 341:3
    347:5 406:7 407:8
called 14:12 53:3
    57:20 64:14 67:4
    79:14 122:9 145:5
    183:5 291:17
    340:14,17 356:7
    371:11,14 406:11
calling 60:21 62:18
calls 39:13 40:10
    69:3 291:18,20
CAMBRA 122:9
camp 298:17,17
Campaign 34:5
cancer 37:9
candidate 3:16,20
    26:9
candidates 121:5
CAPA 209:21
capacities 14:18
capacity 254:7
capture 58:2
    108:22 113:15,21
    115:20 117:14
    121:1 133:14,16
    134:11 138:14
    140:17 155:5,6

173:14 175:14
    177:21 195:15
    214:2 237:2 239:3
    239:13 254:3
    289:18 293:5
    310:16 320:15
captured 54:16
    71:8 106:8,10,16
    107:10,18 108:12
    109:7,11,16 111:7
    135:5 181:2
    259:19 289:10
    301:13,14 341:13
captures 135:20
    356:13
capturing 83:6
    133:13,22 134:3
    214:4 260:2
    369:20
car 384:6
card 11:3,18 24:14
    112:11
cardiovascular
    13:17 50:10
cards 11:3
care 1:20 4:16 8:20
    10:7 18:14 22:10
    30:18,19,22 32:3
    49:12 50:9,20
    51:21 54:18 82:22
    83:7,19,20 85:1
    87:10,12 89:3
    105:16 112:12
    119:22 130:21
    142:3 155:18
    184:5 194:9 198:6
    210:4,6 214:3
    226:2 260:22,22
    261:2 267:18
    276:6,9 278:6
    282:14,16 285:17
    285:20 286:2,15
    287:2 291:5,7,19
    292:14 301:7
    305:2,18 307:20
    315:12 324:5
    325:7 327:12

329:18,21 331:8
    334:4 338:7
    340:14,16,17,20
    341:5,6,12 342:14
    347:12 348:1
    350:19,20 352:6
    355:15 357:4,8,9
    358:11 361:12
    362:11 363:3
    369:1,2 372:11
    375:3,6,8 376:13
    377:1,3,4,10
    378:6,8,15 379:22
    381:15 383:22
    386:22 389:22
    394:5 397:13
    398:14
carefully 390:6
caries 4:4,7,10
    86:13,14 91:9
    92:1,4,16 93:11
    94:13 95:2 96:3,7
    96:14 97:8 117:17
    117:18,20,21
    122:10 138:12
    162:11 204:21
    207:16 218:10,11
    218:14,20,21
    221:15 222:10
    223:21 228:19,20
    259:5 295:1 317:1
Carillo 1:16 18:2,3
    54:6,11,21 66:4
    146:22 147:5
    149:1,7 150:1,5
    160:17 161:1,6,9
    161:12 340:19
    351:7,9 352:14
    369:12 396:22
    397:7,16
Caritas 1:14 10:7
Carol 72:2
carried 173:4
carve 79:14
cascade 21:10
case 10:18 24:12
    49:10 51:15,22

52:18 66:18 103:6
119:4 137:8 201:3
271:10 288:18,21
298:14 324:3
327:3 332:19
362:13 368:18
369:4
cases 51:12 52:15
54:4 63:13 91:16
118:9 119:3 130:8
327:1 346:18,19
399:16
casino 11:3
catch 390:20
categories 53:5,13
categorizing 287:3
category 35:16
97:10,12 111:4
132:17 329:1
cause 360:21
causes 50:11
350:14
cautious 168:22
CDC 57:17 122:7
388:13
CDT 101:12,16
117:11,14 129:9
132:7 181:3
194:21 195:4
196:11 197:8
229:21 281:17
cell 373:13
center 1:19 2:4 6:2
12:2,2 17:6 21:13
376:13 380:6
Centers 1:13 13:1
central 338:13
cents 375:17
CEO 11:5
certain 21:6,9 39:8
82:11 94:15
100:17 143:11
164:14 207:6
228:21 258:3
331:6 357:18,22
370:2 390:5 403:9
certainly 45:17

91:8 92:8 104:8
135:3 210:18
222:14 244:15
263:18 264:11
270:22 327:7
370:2 377:21
378:11
cetera 42:22 51:19
53:9,12 63:12
98:19 99:22
168:14 222:17
256:17 400:15
chair 16:7 19:9
74:15 144:19,20
145:11 388:9
chaired 291:10
chairing 22:4
chairs 22:2 25:13
154:5
challenge 46:22
94:18 95:10,11,14
95:18 116:4
137:12 159:7
193:14 304:15,21
306:4,10 309:18
309:20 343:5
369:6
challenges 43:10
218:3 293:14
309:15
challenging 45:5
236:22
chance 177:10
279:6
change 82:14 104:2
144:12 201:21
217:21 237:5
238:15 240:8
243:16,20 245:22
251:6 252:18
253:9 254:11,13
283:5,10 314:12
323:12 324:19
325:18 370:15
changed 79:2 80:20
203:4 206:8
240:10 280:5

changes 23:15
38:13 69:17 108:3
115:19 245:20
306:7 319:1,9
386:8
changing 93:18,18
237:20 306:8
characteristics
94:21 257:7
355:15
charge 13:7 23:6
chart 176:21 333:1
check 71:22 203:10
203:12 303:17
337:5,10
checking 232:9
353:4
checks 409:17
cherry 141:12
chew 44:1
chewing 261:10
Chiang 1:17 13:18
13:19 14:8 151:10
152:15 156:15
168:10 181:18,22
202:15,19 225:14
229:13 251:19
Chief 15:4 16:2
child 1:20 15:13
22:5 53:9 89:21
93:13 94:22,22
98:16,17 101:21
102:3,5,9 107:4
115:12 118:13
119:21 120:14
121:3,10 134:22
141:5,6 201:14
211:18 212:12
215:21 216:1,4,5
216:7,10 264:13
265:12 271:2,9,18
272:1 276:11
283:21 285:17
286:2,11 287:7
290:8 292:1,3
294:21 305:2
316:17 350:18

354:12
child's 120:19
287:12 290:19
317:18
childhood 92:16
100:20 218:15
221:15 331:9
394:9
children 4:4,7,10
77:18 82:4 83:21
92:17 93:3,11
95:1 96:2,7,15
98:10 100:14
112:2,18 162:11
177:22 204:20
207:16 208:2
212:1 215:3
217:15,16,18
223:3 225:11,12
234:15 239:6
254:22 257:21
258:3,4 259:4
260:18 263:17
265:12 266:1,3
269:22 279:11
283:13,19 293:19
294:9 305:2,18
307:19 315:14
316:1 331:4 353:1
356:4 360:21
361:13 377:22
383:17 398:13
children's 97:6
chime 41:16 129:15
Chip 77:19 90:4
105:12 141:15
233:18 245:4
246:2 253:7
266:17 267:16
321:2 342:11
Chisara 1:13 12:21
259:13 261:8
choice 99:1 355:6
choosing 62:20
chosen 75:1 79:13
216:4
Christian 272:7

chronic 100:20
138:1 331:9
347:16,17 350:17
churn 111:11,12,17
circle 363:22
circulate 42:14
67:17
circumstances
127:9 138:20
cite 335:15 393:6
cited 327:8 330:5
cites 301:18
city 14:15 372:1
392:15
claim 108:20 113:1
129:7,12
claims 75:17,19
109:8 129:18
130:4 155:7
176:20 187:10
193:11,12,20,20
194:8 196:2,9
231:15 266:21
293:5 310:13
333:17 349:7
400:2 404:13
claims-based
128:22 129:3
clarification 100:3
105:1 117:1 357:6
358:8
clarified 116:17
clarify 104:22
124:13 125:1,12
126:1 132:19
202:5 330:1
351:13 356:19,20
clarity 403:4
class 27:21 361:7
classic 369:14
classified 407:21
clause 86:16 216:2
clean 34:1
clear 58:22 82:16
98:11,14 101:10
101:20 104:9
105:15 151:12

174:14 274:10,11 274:14 281:9 315:5 342:13
clearer 84:18 380:18
clearly 45:10 77:20 87:15 92:13 93:21 97:17 114:3,12 134:16 139:2 218:10 227:20 228:5 234:14 244:8 252:12 253:21 267:17 271:3 301:19 332:14 360:18 376:2
click 127:13 145:22
clicker 123:11
clickers 315:1
clinic 16:18 30:4 46:8 210:5 381:10 381:21
clinical 13:1 14:1,2 16:11 30:22 31:1 32:3,13 52:10,22 56:7 64:18,22 65:8 88:14 96:18 97:2 138:3 139:11 183:3 224:2 229:7 297:22 316:22 317:5 346:7 376:11,19
clinician 21:8,12 44:4 51:16 52:3 117:20 132:20 133:20 210:5 381:22 385:14,16
clinician's 381:11
clinicians 47:3
close 146:16 162:4 174:9 185:13 192:14 198:17 200:3 316:7
closed 115:17 151:5 191:18 204:17 232:22 234:9 235:17

249:9 250:5 259:1 263:4 264:6 265:3 266:11 267:9 268:7,22 296:1,17 307:12 308:16 309:11 310:8 311:4,22 328:6 330:20 331:17 334:20 337:19 343:17 394:19 398:6 399:5 402:12 404:7 405:1,20
closely 60:4 85:7
closer 82:10
closes 156:10
cloud 65:21
cluster 164:10
CMS 9:6 13:2 18:10 78:7 80:14 80:15,20 81:9,20 82:3 84:14 143:16 185:1 212:3 215:20 216:9,16 217:14 220:2,3 227:7 228:4 238:1 238:5 252:16 267:17 287:5 349:7 356:2 360:1 364:15,18 372:2 373:15,15,16 379:5
CMS/Medicaid 221:7
co-chair 1:12,12 46:3 61:21
co-chairs 1:10 41:1 68:14
coating 231:17
Cochrane 85:9,14 87:21 88:1 96:19 96:22 208:18 248:1,4 293:22 301:18 318:14 323:8,9
code 86:17 101:3 102:18,20 122:7,8

133:6,21,22 134:11 135:1,11 136:7,8,13,13,19 138:8 155:6 271:21 283:7,8 289:12 305:3 332:8,9 333:14 352:18 353:3 373:11 392:10 399:12,18 407:22
coded 102:16 129:8 241:20
coder 352:17
codes 75:17 86:6,7 86:8 101:12,16 106:11,16 112:22 113:15 117:11,11 117:14 118:5,15 118:15,16,17 119:11,12,17,18 121:22 122:4 129:8,9,9,10 130:16 131:12 132:1,7,9,10,12 132:13,15 134:18 135:13,15,19 139:8 140:7 155:5 155:8 181:3,6 186:20 194:21 195:4 196:11 197:8 229:21 242:1 271:14,17 281:8,17 288:8 293:6,9 309:2 310:16 333:12 395:6 406:19,22
coding 38:13 75:15 86:10 117:13 129:12,17 135:9 281:3 304:17,18 401:9 407:20
cognizant 283:14
cohort 176:12 225:21 255:4,15
cohorts 226:5,10 227:1 256:1
COI 9:10

collaborating 58:19
collaborations 57:19
collaborative 14:4
colleague 29:5
colleagues 6:19 90:6
collect 229:11
collected 229:22 349:4
collection 155:20 198:8 218:2 229:20 341:16
collects 348:10
College 1:16 17:8
collegial 25:7
Colorado 12:13
Columbia 12:3
column 35:9,20
combination 82:1 158:14
combine 7:7 350:11
combined 83:13 126:14 291:2
come 23:20 29:20 30:3 39:4 41:4 44:1 46:1 54:17 67:6 72:17 111:13 112:12,22 138:4 138:17 140:1,14 145:10 164:22 169:15 170:14 172:7,13 177:16 194:18 227:17 236:18 240:13 260:10 273:17 282:17 294:9 304:12 338:1 361:16 364:3
comes 88:9 109:8 116:1 130:7 176:12 254:17,17 255:18 338:15 339:20 351:13 364:14 374:13

comfort 108:6 381:13
comfortable 20:7,9 20:11 236:14 379:14
coming 9:12 53:6 67:4 129:18 144:20 152:17 170:17 203:13 360:5 374:11 401:15,16
comment 3:19 4:20 5:19 6:7 26:17 40:13 46:13 63:6 66:17 68:6 99:5 106:6 132:19 136:4 138:9 139:14 142:22 157:7 175:14 180:22 193:6 205:4,6,8 211:6 213:22 231:14 237:14,15 239:12 241:13 247:16,21 275:2,22 280:12 299:22 304:7,9 312:14 314:16 330:6 333:20 353:8 356:20,21 359:21 365:8 390:10 391:2,5 400:7 401:3 406:5 409:12
commentary 157:13
comments 23:2 26:2,18 40:15 61:1 68:5 73:22 106:1,5 116:16 153:1 155:11 157:19,21,22 158:8 173:14 176:8 181:13 184:17 187:18 193:4,17 199:2 200:10 205:11 208:13 245:2

247:17 249:2,19
249:21 250:12,16
250:19 251:16
255:22 259:11
264:18 268:14
296:18,22 303:15
304:11 308:6
309:3 311:15
317:9 341:17
343:10 391:7
393:21 400:4
402:19 405:13
409:2
commercial 77:7
78:5 90:4 115:8
115:22 139:17
193:22 194:1,3,6
220:14,15 240:2
245:4,6,12,20,21
246:7 248:21
249:16 253:10
266:18 307:1
commission 78:14
Commissioner
14:14,16
committee 1:3,8
5:7,11 7:17,18 8:5
8:11,15 11:16
13:11,17 16:1
19:3 20:16 22:13
23:5,13 24:10,12
24:18,22 25:8,11
25:12,17 26:12
27:1,22 28:6,6
32:18 33:8,16
36:8,22 38:3
40:15,21 41:6
42:13 46:2 52:15
56:13 60:21 61:21
63:21 65:17 67:18
73:17 74:16 89:9
99:17 120:6 126:1
149:4,14 153:2
164:20 165:3,9
166:12,21,21
167:5,7 169:20
170:1,5,14 173:7

175:18 181:11
188:15 189:2,6,19
202:12 204:4
210:18 233:11
234:19 237:9,13
240:15 250:20
252:3 278:20
279:1 298:8 302:8
304:10 312:10
319:13 321:10
328:20 339:14
348:22 364:5
366:5 371:4,5
409:10
committee's 6:8
171:14 179:1
297:6
committees 20:4,5
48:21 49:3,4 70:2
170:11 213:1
240:14 278:10,12
common 1:18 11:6
79:18 100:20
223:1,1 231:19
331:8 403:12
commonly 103:8
181:3 332:21
communication
59:20
communities 36:21
41:22 42:4 48:14
60:12 361:16
381:18 387:19,22
396:5,9,11 397:11
397:11,12,12
401:8
community 1:21
3:14 14:19 15:11
18:3 21:12 30:4
31:19 34:22 35:1
35:15 36:16 37:5
41:20 42:7 45:7
45:10 47:1,3,19
48:11 52:6,11,12
56:20 59:1,5
60:13 61:11 63:19
66:10,18 67:11

81:18 85:18 88:21
109:5 111:16
130:21 270:14
280:3 290:2
323:16 348:2
353:11,12,20
354:7 355:6,15
358:4 362:11
363:15 364:10,10
365:2 370:14
371:1 373:2 375:3
378:9,18,20 380:6
381:16 385:10
388:2 389:22
397:4 401:18
community's 386:4
community-based
43:18 369:2
community-level
372:11
Companies 1:15
companion 47:2
company 13:7
comparability
150:18 192:6
comparable 47:4
47:10 240:1 383:6
387:19
compared 115:10
387:3 396:16
397:14 403:5
405:11
comparing 388:14
comparison 387:9
387:11
compelling 238:15
compensated 133:8
compete 260:6
competency 54:12
competing 161:20
204:12
competitive 90:1
compiled 79:5
complain 365:11
complete 148:1
240:16 287:20
337:8 401:22

completed 25:15
212:19 228:1
276:15
completely 244:9
304:20 352:12
complex 43:15
complicated
217:22 281:18
363:6 380:2
397:16
complications
270:7 347:17
complimentary
64:13
comply 80:21
component 48:19
84:7 229:5 276:10
338:14 359:15
components 50:17
88:12 110:16,20
145:1 228:16
349:20
composite 152:11
202:9
composites 34:8
composition
228:20 245:21
246:2,6
compositives 192:8
comprehensive
34:6 270:1 278:22
280:15 281:2,12
281:20 282:12,17
292:5 305:5
315:16 316:17
322:17 336:19
338:11 348:17
373:21
compromise 345:1
computer 225:2
con't 4:1
conceivably 379:5
conceive 284:16
concept 30:8 76:7
110:3 130:20
200:19 212:17
322:13 324:13

336:9 359:13
370:11
concepts 338:10
339:2
conceptualize
359:20
conceptually
359:18 360:16
concern 75:10 76:6
81:5 85:2 87:9
111:14 163:12
171:9 193:10
196:15 200:13
203:5 215:1
225:16 239:2
242:15 245:19
263:19 338:20
373:12 401:15
406:18
concerned 211:16
236:11 242:5
251:21 258:9
concerning 169:3
concerns 33:5
73:21 75:7 84:8
84:10,21 89:8
102:10 103:18
143:7 150:7
169:21 187:18
192:21 193:7
198:4 200:10
247:4 252:8
260:16 288:3
400:3 404:12
concise 26:2
conclude 231:2
concluded 395:9
410:5
conclusion 321:15
concordance
176:20 333:16
concur 354:3
concurrently 289:3
condition 288:11
347:13 378:7
400:22
conditioned 320:13

conditions 114:18
317:17 350:17,18
369:19 370:6
372:13
conduct 66:9 187:8
conducted 148:12
conducting 148:6
conference 1:8 6:2
95:8 179:9
confidence 244:16
247:7
confident 206:11
207:13
confirm 92:7
confirms 92:11
conflict 7:22 18:21
19:2,4
conflicts 8:2 319:2
confounded 377:7
confounders
378:12
confused 313:4
confusing 312:22
confusion 206:6
connected 64:21
273:12
Connecticut
105:13 158:19
342:12 405:7
connection 96:10
247:22 274:17
277:15 316:20
connects 273:4
375:2
consecutive 28:7
315:15 316:18
320:9,10,19,22
consensus 23:5
26:7,22 78:17
88:18 169:19
170:9 171:19
223:6 231:1
248:14 296:3
303:18 313:6
334:6 340:2
364:12
consequences

123:19 160:7
185:7 199:18
342:19
consider 30:11
152:6 186:3
213:18 217:14
324:21 335:14
357:7 370:8
384:17
considerable 88:14
128:2 184:3
228:11 329:5
considerably
221:21 367:8
consideration 3:16
3:20 9:8 43:3
54:22 238:10
239:21 257:2
380:3
considerations
153:1
considered 17:9
24:20 108:16
218:2 223:11
234:1 236:5
267:18 336:2
382:13
considering 65:1
186:10 361:22
379:11
consistency 87:18
127:5,6 170:19
171:17 174:18
182:4,11 238:10
consistent 93:4
102:10 135:9
139:9 150:13
170:11 192:1
202:21 220:7
246:4,5 253:5,7
286:18 310:13
344:6
consistently 148:1
constant 41:13
94:7
constantly 278:10
constituted 288:6

construct 243:22
323:3 368:14
376:21
construction 351:1
consult 19:9
Consultant 2:14
7:3
consulting 7:21
contents 41:7
context 28:15
49:10 143:9 244:4
272:8 286:11
289:9 349:9
353:10 362:18
381:1
contingent 39:20
continue 99:3
105:3 162:19
306:13
continued 3:20
282:14
continues 251:12
continuing 23:12
94:3
continuity 4:16
85:1 87:10,12
89:4 273:17,18
276:22 278:2,6
315:12,13,22
323:4,21 324:6,8
324:9,16,22 325:7
326:3 327:6,7,9
327:11 329:18
336:17 338:6,8,19
340:7,14,16,17,20
341:7
contract 89:22
143:15 144:2
contracted 254:2
contractor 245:11
contractors 253:22
contribute 26:3
306:11
contribution
317:15
control 303:13
378:9

controlled 97:16
301:19
controlling 218:19
convene 41:6 49:13
78:9
convened 50:12
conversation 69:5
175:20 176:17
186:7,10 232:1,4
299:14 306:1
359:5 371:2
374:10
conversations 64:9
72:14 163:6
convincing 233:10
coordinated 324:11
coordination 18:15
50:9 57:7 230:17
copies 168:2
copy 147:4 166:11
409:20
core 42:3 50:2,15
86:19 196:1,4,16
197:13,16,19
Cornell 1:16 18:6
corner 146:1
correct 24:10,15
150:5 153:19
154:1 186:11
190:7 197:10
200:17 240:11
283:2 335:17
358:6 362:1 366:8
393:20 397:19
correctly 197:6
272:16 279:10
408:20
correlate 65:11
correlation 277:8
376:22
cost 341:15 348:7
counsel 2:8 5:10
count 286:9 356:14
counted 285:15
356:12 367:16
408:20
counties 372:18

387:12 403:9,11
403:13
counting 296:4
Countries 92:22
country 66:12 79:8
95:19 122:13
211:7 212:7
counts 271:9
360:16,17
county 31:15 45:9
83:3 95:13 355:11
366:12,18 367:2,7
367:9,9,14,17
368:3,4,10 371:22
372:17,21 373:8
379:8 382:9,21,22
387:7 388:6,6
392:13,15 403:10
403:15 406:12,13
couple 5:13 19:19
22:8 45:15 61:6
153:22 162:22
169:3 207:3
240:19 322:8
372:4 377:8 385:1
course 15:15 75:10
76:7 78:21 152:2
239:3 314:12
359:11 360:1
377:6 407:3
cover 69:12 293:9
coverage 108:2,3,4
108:7 111:8 115:9
116:3 215:15
216:8 217:17
covered 78:4
114:22 115:3
119:15 120:11
217:18,20 288:12
325:4
cracks 214:11
Crall 2:13 73:7
74:9,15 76:10,12
88:19 89:14 90:20
92:8 108:17 113:4
113:22 117:17,19
119:6 122:2

131:10 132:18
133:15 134:12
135:12 137:6
143:2 176:7
197:20 201:17
211:21 213:21
215:19 216:11
218:6 222:12
227:4 239:17
243:10 244:7
245:3 252:11
270:19 285:10,13
286:6 288:10,15
290:3 301:3 303:5
303:8 316:4
326:11
Crall's 239:12
create 178:10
370:20 371:6
created 60:20,21
253:12
creates 365:16
creating 93:19
373:10
creatively 64:20
credible 159:17
160:3,5 199:15,16
criteria 22:19,20
24:3 25:20 27:6,8
27:9,12 43:8
44:18 69:12 87:19
116:8 151:14
155:2 157:3
161:16 165:4
173:18 175:11
187:21 189:3,4
204:7 209:19
210:16 250:22
251:14 260:11
388:20 393:22
407:12 408:6
criterion 105:5
116:9,20 145:17
150:4 151:22
152:7,8,21 153:21
158:1 163:3,8,10
163:10 166:7,15

167:3,9 171:22
177:13 180:2,5,15
181:11 192:19
241:1
critical 92:20
103:14 333:8,10
343:21
criticisms 170:9
crossed 337:9
CSAC 23:4 40:18
40:20 41:2
cultural 54:12
culture 54:12
cumbersome 81:3
126:5
cup 9:17
curious 39:9 137:1
current 33:7 36:18
60:13,19 78:20
119:18 131:14
189:16 199:1
221:4 227:6 228:7
267:14 287:5
350:22
currently 10:17
13:5 14:10 17:16
26:11 48:2 84:14
105:11 136:8
210:10 213:16
218:18 228:7
249:13 260:7,10
267:14 306:21
311:8 340:7
342:10 362:19
405:6
curve 20:6
cut 34:18 247:6
cut-off 216:5
cutting 209:13
cycle 172:8

————————————
D
————————————
d 152:12 318:1
D.C 1:9
dare 364:18
dark 388:18
data 57:5 70:7

75:13,17,19 77:3
77:9 79:5 82:2
83:6 90:3,5 92:11
92:13 94:11 98:8
98:20 100:13
103:7,8,14,20
105:7 106:6
108:21 109:8
112:15 113:20
120:15 123:16
128:1 129:21
134:14 135:8,12
135:17 137:2
138:19 140:11
141:7 145:3,12
148:12,17 149:19
150:18 155:18,19
155:21 176:21
184:2 185:5
187:10,12,13
190:12 192:7
193:5,6,11,11,12
193:15 196:9
198:6,7,9 212:3
218:2 219:14
227:17 228:2
229:11,20 233:10
233:18 236:2
239:2 244:6 245:6
245:10 248:20,22
251:2 252:21
253:1 254:10,10
254:13 266:15
270:6 272:6 278:4
292:9 293:3
310:12,14 316:6
320:20 321:4
322:18 325:21
327:1 329:4,17,19
329:21 330:8
331:2,4 332:20,21
333:3,8,10,13,14
333:17 337:4
341:9,15 346:8
348:10,20,22
349:9 356:18,22
361:3 367:19

389:10 396:16
397:19 400:1,3,12
400:14,18,19
401:4,7,13,18,20
401:22,22 402:3,3
403:13 404:14
405:7
database 293:5
348:17,18 356:10
356:13
dataset 293:14
datasets 400:13
date 39:8
dated 94:12 218:13
David 1:19 10:11
108:19 120:17
135:19 158:10
168:16 194:15
247:13 257:18
272:13 316:14
329:2 353:7 354:5
Davis 2:15 346:6
day 78:20 172:2
289:15 321:13,13
408:13
days 6:4 22:8 45:15
111:19 112:6
356:11,15 388:16
399:17
deadline 40:9
62:13
deal 78:22 79:15
85:14 99:17
dealing 143:8
deals 74:21
dealt 221:19
dear 85:22
debate 111:15
decade 82:9 208:20
361:4
decades 82:10
decay 92:17 96:15
96:15 120:21
180:17,20 331:4
decide 157:8
328:19,19 342:22
353:19 354:14

364:19 386:20
decided 306:14
325:6 350:10
354:17 409:10
decides 105:8
341:10 352:18
353:16
decision 152:18
213:2 254:6 298:9
decisions 253:18
decrease 397:1,3,3
decreased 396:15
402:22
decreasing 383:18
383:20
deep 363:8
deeper 406:16
deeply 274:7
default 179:7,8
defaulted 335:2
deferred 360:4
define 94:21 101:5
181:8 197:8
215:20,22 216:4
226:18 275:12,15
386:10
defined 52:19 63:2
80:17 81:8 236:1
237:19 305:2
351:20 393:15
407:13
defines 216:7 356:3
defining 132:16
264:11
definitely 41:16
55:22 62:3,4
65:16 84:19 172:1
176:22 209:14
230:5 255:20
256:4 283:10
284:1 314:2
327:17 330:9
336:10,20 364:17
definition 45:7
81:3 101:11,17
102:11 215:14
216:10 318:4

334:7 349:1
359:17
definitions 50:1
degree 77:2 120:5
171:6 206:5
210:21 244:16
393:13
dehydration
346:16 349:22
350:1,13 352:19
352:21 353:3
376:11 377:12
383:18 392:10
399:15
delay 314:18
344:12,13 409:10
delaying 314:21,22
315:4 344:13
deliberations 6:8
6:14
delighted 30:6
delineated 97:18
deliver 276:5
delivered 292:14
delivery 18:11
30:22 32:3 110:11
142:9 154:22
214:9 215:6 217:7
223:18 307:1
394:5
delphi 335:13
336:1,3 338:7,9
339:1,8 350:8
Delta 1:18 16:3
demonstrate
135:18 137:15
144:5,11 176:19
329:5 376:17
392:21
demonstrated
96:14 123:16
128:2 158:12,22
159:12 160:4
184:2 185:5
199:16 233:20
248:19
demonstrates 98:9

demonstrating
159:18
denominator 98:13
101:2 107:22
117:6 133:13
134:8 145:2,5,5,6
145:7 186:13
196:19 251:11
259:20 264:14
320:12,15 332:3,4
332:13 334:7
348:3 366:1,7
369:8,18 371:9
392:11 399:20
denominators
83:10,11 196:21
dental 1:18 2:12,13
2:13 4:3,5,6,8,10
4:11,12,13,14,15
4:16,18 16:2,3
70:6,8 72:10,11
73:5,6 74:11
75:13,19 76:7
77:12 78:12 79:6
79:7,9,14,20 80:8
80:16,17 81:15,21
82:4 83:1,3,12,16
83:18,22 84:6
88:21 90:11 91:9
92:1,4 93:7,14
96:1,8,12,15,19
98:10 100:14
101:3 102:15
104:7 106:7
107:17 115:10,15
117:12 120:8
129:20,22 130:1
130:12 139:18,19
162:10 177:19,21
204:20 207:17
208:12 210:9
211:7,15,18 214:4
218:14,19,21
230:20 239:16
259:5,9,19 260:14
260:18 262:16
264:13 265:11

269:2,19 270:13
270:15,18 271:12
273:18 280:9
284:6 286:3
304:18,18 315:12
316:1 327:15,15
329:7 331:7
333:12,15,16
390:13
dentist 15:19 80:19
81:10,12 82:17,20
84:1 107:2,12
132:3 136:18
194:19 225:18
230:15,15 274:20
281:21 288:11
dentist's 274:16
dentistry 75:13
88:9 122:15
208:17 292:13
295:14 306:2
317:8
dentists 210:6
223:18 281:3
292:14
department 1:20
5:6 15:11 31:15
52:20 288:6
353:18,19,22
354:12,13 376:14
department/obse...
353:14
depend 161:19
204:11
dependant 155:7
dependent 255:1
depending 133:17
172:16 382:22
depends 130:13
147:6 216:6
derived 50:15
348:7
describe 44:8
described 53:4
202:6 332:14
describes 106:16
describing 359:8

description 122:6
208:1 221:4
269:20,21 283:9
descriptor 117:22
122:7
descriptors 281:1
design 138:18,21
139:10 140:12
222:13 227:15
282:2
designated 24:4
137:16
designation 117:19
designed 347:14
designers 248:19
designing 137:12
desire 33:2
desk 147:4
Despite 33:14
detail 23:9 56:3
166:5 178:17
details 121:8 124:4
186:12
detection 317:17
determinant 38:1
determinants 31:5
31:21 32:8 41:12
52:13 53:11 55:9
56:6 65:2 358:3
362:21 367:11
369:16 373:6
376:2 377:7 380:4
384:1 386:7
determinate 33:12
35:17
determinates 33:19
35:5 36:15 362:17
determination
102:8
determine 101:12
101:18 102:2,5
139:1,12 334:6
determined 97:7
138:16 194:21
351:21
determining 188:2
deterministic 370:6

develop 74:5 78:19
79:3 121:1 134:19
143:22 290:9
developed 31:13
69:15 80:10
122:11 142:2
171:16 173:6
229:8 260:9
271:20 303:17
developer 30:7
203:7 237:5
240:15 255:21
270:3 283:4
345:17 346:6
developers 23:18
24:4,13 25:9,13
26:10 32:19 33:3
38:11 69:16,19
70:13 90:19 100:2
140:8 165:4 166:2
167:17 177:17
188:10 233:9
252:4 257:17
260:21 262:13
263:9 265:15
275:22 280:21
299:17 300:6
307:18 308:21
311:10 314:9
315:8,17 373:9
developing 51:12
53:2 97:8 122:20
178:22
development 17:6
17:13 26:7 74:16
120:6 156:21
170:10 171:19
226:10,11 271:15
283:20 336:5
350:7 359:3
developmental
229:2 294:12
developments
17:22
device 125:9
DHHS 78:2
diabetes 1:17 13:20

50:9 64:12 70:10
137:20 225:22
375:4 389:6
diagnosed 142:4
276:7,9
diagnoses 351:21
352:6,7
diagnosing 347:18
diagnosis 284:21
285:4,7 287:4
289:1 346:14,15
346:16 349:2,3,21
350:1,2 351:10,12
351:12,14,15,18
351:19 352:3,11
392:8,9,10 399:13
399:14,18
diagnostic 75:14,16
117:12 135:1
271:8 287:10
diarrhea 383:17
diet 229:3
differ 245:16
284:11 285:8
difference 190:3
223:20 244:19
254:11 274:12,14
281:17 283:12
286:4 383:12
differences 25:7
150:17 192:6
228:13 233:20
251:3 375:14
393:16 401:8
different 7:22
21:11 58:7 62:17
80:2 84:9 91:13
109:20 110:8,9,15
112:15 114:1,2
119:14,15 129:19
151:13 152:4
168:17 170:2
174:16 179:14
180:5 186:21
187:12,14 190:14
202:8 219:8
222:17 223:14

226:10,11,14
228:13,16 233:22
236:7 238:22
239:15 242:17
245:14 254:20
255:4 280:14,18
284:15 285:5
287:22 290:15
300:20 306:13
316:5,11 324:11
327:18 336:5
339:18 340:1
352:12 353:20
356:13 380:10
387:21 397:1
403:21
differential 145:8
262:14
differentiate 95:1
144:4 222:18
differentiation
83:11
differently 98:1
275:3
differs 349:18
difficult 59:6 137:3
168:18,20 174:20
325:9,13
difficulty 151:21
dig 145:3,12 406:16
diligent 205:21
dimension 368:7
dinner 409:13,18
direct 81:17 88:13
107:1,14 109:12
145:21
direction 81:11
83:14 87:20 131:9
228:6 275:17
directions 23:4
241:19 242:17
243:21
directly 19:10
54:19 66:19 79:15
82:17 97:10
329:22
Director 2:9,10 5:5

10:18 12:1 13:6
16:4 47:17
directors 27:2
113:7 255:13
disabled 255:6
disagree 136:17
disagreement
169:10 173:13
discharge 400:15
400:21
discharges 348:11
348:14 392:6
discipline 207:7
disciplines 80:6
disclose 7:16 8:8,18
9:1,5 10:14,19
11:7,13,15 12:14
13:13 15:7 16:16
18:16
disclosure 3:5 5:12
7:20 13:9 15:1
disclosures 7:8
10:9 12:4,9 13:22
16:5 17:18 18:19
19:12 319:2,9
discount 255:13
discretion 303:10
discriminate
231:17
discuss 19:13 40:15
41:7 45:14 68:5
70:22 167:15
237:10 259:13
289:7 346:11
391:15
discussant 171:3
185:20
discussants 163:2
discussed 61:3
167:13 179:10
252:10 263:12
308:4 309:19
discussing 16:12
165:3 248:14
251:22
discussion 21:17
23:21 24:1,7,11

25:6,21 26:3
54:17 65:19 73:13
98:4 99:13,18
100:1,11 103:21
109:19 124:8
154:17 157:21
164:5 166:10,21
167:6,7,10 168:7
168:13 175:10,12
175:18 176:6
177:8 178:6,8,15
179:5 180:5
181:15 186:17
188:17 202:14
208:8 210:16
214:14 215:9
218:7 233:8 234:3
235:9 236:9 241:4
243:4 247:3 249:3
257:10 261:4,5,20
262:19 263:22
266:5 267:2,21
272:13 278:20
279:1 295:16
299:15 307:4
310:1,19 314:10
314:21 318:18
320:5,7 326:18
327:21 329:13
330:13 331:11
334:13 335:9
337:13 351:5
365:19,21 366:3
366:21 367:1
374:15 384:14
387:18 392:2,20
395:11 398:18
404:15 406:4
408:2
discussions 18:1
65:6,7 155:4
213:14 350:9
381:1 403:7
disease 9:6 35:1,16
36:4 37:6 70:10
100:15,17,19,20
118:20 119:1

134:22 138:2
143:5 218:14
221:18 331:5,7,9
347:16,17
diseased 258:7,7
disparities 98:21
141:11 184:5
188:9,10 190:4,13
190:15 233:12,16
258:13 329:8,20
372:7 395:5,22
396:2,13 397:8
disparity 256:19,20
397:7
display 160:21
displayed 161:4
displaying 161:1
dissimilar 223:6
distinct 283:12
349:3
distinction 361:20
406:20
distinguish 227:3
358:10 360:13
380:15
distinguishing
379:20
distort 136:10
distortion 137:2
distracting 157:7
distractions 25:22
District 12:3
divergent 174:5
241:19 243:20
divided 227:1
diving 116:7
doc 46:7
docs 380:6
doctor 10:6 282:11
doctors 217:21
324:19 378:8
document 104:11
141:3 173:5
187:21
documentation
224:17,22
documented 98:12

doing 14:22 17:21 20:15 28:2 30:14 31:7 40:22,22 47:4 55:12,13 57:14,21 58:3,12 58:22 68:20 90:8 116:11 126:6 144:1,16 151:21 162:22 174:15 197:18 211:13 221:13 292:20 313:1 342:21 371:3 372:8 379:19 386:19 407:10
domain 54:14 323:16
domains 34:20 35:9
dominating 26:2
Don 31:13 32:1
door 274:16 277:11
dotted 337:8
double 339:3
downside 217:12
downwards 243:16
DQA 78:6,11 80:9 80:12 82:15 83:9 88:19 89:17 106:2 117:1 136:1 140:8 145:4 158:6 178:21 339:18
DQA's 76:17
Dr 22:4 73:7 74:9 74:15 76:10 88:19 89:19 90:20 96:3 113:4 129:15 131:16 176:7,22 201:17 211:21 215:19 231:14 239:12,17 285:10 285:13
draft 60:20,21 67:18 224:12 336:9 337:2
drafting 26:16
drastic 314:14

draw 50:18
drew 10:2 18:15
drill 372:19 384:13
drive 57:7
driven 52:8 66:19 367:10,11 386:20 386:21
drivers 387:20
driving 388:4 394:6
drop 114:7 394:2
drop-off 255:2
dropped 114:8 396:6 397:10
drops 241:16 243:15
dry 116:12
due 38:7,20 75:2 254:22 292:6 350:16 400:11
duplicating 58:4
duplicative 29:11

_____
E
_____
e 152:12
e.g 400:13
earlier 30:14 69:18 83:6 158:15 162:14 188:21 265:9 308:4 314:6 366:4 403:3
early 40:2 92:16 93:12 105:16 120:20,21 135:4 221:14 317:16 342:15
earned 344:15
easier 147:21 360:12
easiest 256:15
easily 24:8
Eastern 68:1
easy 93:19 264:12
EBSDT 216:16
economic 31:5 33:20 35:5 36:14 395:6

ED 354:13,18,20 355:4,19,21
edit 390:6
editorial 283:6,10
editorially 84:17 341:1
educated 139:8 385:13
education 53:12 129:4 289:8 329:11
effect 223:9 237:21 257:6
effective 18:21 91:12 222:5 223:11 224:9 226:8,16
effectively 57:4,9 360:10
effectiveness 96:14 136:15 222:19 223:7,21
effects 21:11
efficacy 222:1,10 224:20,22 225:15 226:6,21 227:2 309:18
efficiency 290:7 359:15 368:6
effort 57:20 59:13 60:10,14,18 62:5 130:18 244:2 270:21 286:14,21
efforts 22:7 55:21 57:15 58:7,14 61:16 63:16 223:13 237:22
eight 26:6 37:4 128:14 184:12 198:18 394:3 408:19
either 22:14 60:11 87:17 102:8,9 107:14 165:18 171:2 175:19 208:4 222:13 252:15 287:16,16

299:18 318:6 321:12 365:5 383:2 385:11,14
either/or 265:16
elaborate 364:9
electronic 155:19 198:7 341:12
electronically 341:14
element 103:14 149:19 323:21 333:8,11 348:22
elementary 217:3
elements 58:6 67:8 100:6,8 148:17 155:21 198:9 227:10 348:20 400:14,20
elevated 4:4,7,10 96:3 101:11,17 102:3 117:5 162:11 197:3 204:21 207:16 208:3 257:21,22 258:4,5,14,14 259:5
elevators 6:1
elicited 333:20
eligibility 115:19 254:22
eligible 108:15 116:3 182:19 217:15 255:6
eliminates 292:12
eliminating 218:20
Elisa 2:10 3:4,10 5:4 7:7,7 28:1 47:22 48:11 53:4 56:4,11 69:18 71:16 147:13 162:13 206:3
Elise 44:13
eluded 48:12 129:8 135:19
eluding 133:2 152:10
embrace 212:17

eMeasure 155:20 198:8
eMeasures 192:8
emergency 17:4,8 271:6 285:15,22 288:5,15 353:13 353:18,18,22 354:11,13 376:14
emergent 288:11 375:8
emerging 45:21
Emilio 1:16 18:2 146:21 148:20 149:10
emphasis 59:3 94:3 221:14 317:19
emphasize 32:2 36:6 172:19
emphasized 58:8
emphasizing 212:8
empirical 148:6,11 182:15 297:17 298:11 333:2,9
empirically 326:12 326:16
employed 228:8
employer 8:13 78:5 115:22
enable 28:17
enamored 109:18
encompass 281:7
encompasses 346:2
encounter 120:22 279:7
encounters 212:13
encourage 61:5 67:19 214:6 217:5 219:13 256:14 300:6
encouraged 224:8
ended 206:19
Endocrine 36:2
endocrinologist 13:21
endorse 268:13
endorsed 27:21 32:13 33:16 34:17

37:1 38:9 49:20 54:3 63:2 83:15 203:20 205:1 210:10 213:16 214:1 260:7,10 277:5 278:7 279:18,21 300:10 359:14 387:6
endorsement 23:1 26:14 27:19 42:10 42:16 44:21 48:5 53:7 161:14,17,18 161:19 200:8 204:2,6,7,9,11,19 250:12,15 251:18 258:20 259:2 268:15,18 269:1 312:6,11 344:3 387:4 406:3 408:5 408:6
endorsements 178:9
endorsing 177:11 177:12 366:16
enforce 401:6
engaged 17:5,20 25:21
engaging 223:17
enrolled 143:11 194:9 208:2 259:20 264:15 269:22 286:12 315:14,14 320:19 320:22
enrollees 145:2,6 194:14 196:22 197:3
enrollment 112:1 112:16 113:19 320:13 321:5 334:8,10
ensure 174:18
ensuring 25:14 71:7
enter 133:6,21 191:14
entered 193:13

254:10
entering 272:2 286:2
enters 135:1 275:8
entertaining 115:7
entire 34:12 70:22 166:11 169:20 219:6 222:2 271:4
entirely 151:12
entity 79:19
entry 131:16,16
envelope 270:22
environment 33:20 33:22 307:2 373:5
environmental 31:5,18 35:5 36:15 37:22 57:14 58:1 336:8,13 338:22 339:10
environments 34:1
envision 45:1
envisioning 45:11
epidemiological 144:9
epidemiologist 15:10
epidemiology 143:5
episodic 272:3 292:12,16 301:7 307:20
EPSDT 80:20 114:11 238:7
equal 101:22 399:17
equals 102:18
equivalent 277:9 305:6
Eric 1:17 12:11 39:5 237:13 293:16 312:20
eruption 87:1 179:15
especially 7:19 70:3 88:9 155:7 195:20 211:8 213:7 230:4 284:6

313:15 321:1
essential 136:1 317:1
essentially 22:22 56:15 57:22 59:4 159:16 272:17 274:15 335:2
establish 56:18 63:18
established 230:20 283:1 351:19 352:7
establishing 58:20 270:15
et 42:22 51:19 53:8 53:12 63:12 98:19 99:22 168:14 222:17 256:17 400:15
ethnicities 94:16
ethnicity 98:22 233:16 256:17 329:9
etiology 406:22 407:22
evaluate 22:18 152:11 307:19 334:3
evaluated 276:12 322:12 338:8,12 359:14
evaluating 20:7 22:21 169:17 183:3 190:21 358:18
evaluation 3:7 4:14 24:3,17 25:1,19 25:20 37:12 44:18 68:18 71:1 142:13 152:7 172:15 188:16 189:3,17 196:14 269:19 270:2,16 273:11 273:11 274:1,21 280:22 281:7 292:6,20 305:5 315:16 316:18

323:11 336:19 338:10,11,13,17 341:4 358:17,19 410:2
evaluations 281:4 282:2,11 293:8 316:22 317:10
eventually 196:10
everybody 10:10 19:19 49:9 51:13 59:22 71:8,11 116:8 119:19 124:10 154:6 174:19 235:6 304:13 374:18 384:21 407:8 408:13 409:2,14
everybody's 125:9 157:12
everyday 291:18
everyone's 5:14 156:22 388:15
evidence 44:2 69:14 85:9,11,16 87:4,11,15,22 88:6,7,17 89:3,6,6 89:15,16 92:21 96:20 97:1,11,12 97:13,15,16,18 99:9 102:7 105:15 109:9 114:13 116:9,13 122:3,16 124:2 126:8,17,21 127:3,6,10 128:6 146:12 149:2,6,9 149:13,14,15 150:13 151:8 158:21 160:6 166:18 169:5 175:11 179:11 180:16,22 181:18 182:2,4,7,9,10,15 182:21,22 183:3 183:16,19,20 188:5 192:2 199:17 208:18 209:11 210:17,19

210:20 215:9 218:17 219:17,18 219:19,22 220:8 222:9 223:5,15 224:19 225:8 232:6,11,12,14,15 232:18,18,22 233:3,4,15,22 247:21 248:2 260:20 261:13,21 261:22 262:3,4,8 262:10 270:8,12 272:8 273:2,7,14 273:20,22 274:9 274:19 278:15,15 280:4,11 283:11 283:13 284:2 293:1,2,21 294:2 294:4,18 295:4,5 295:6,8,16,18,20 295:21 297:4,7,10 297:17,19,22 298:4,12,15 301:22 302:4,6 303:4 309:17 313:21 317:6,14 317:21 318:2,5,8 320:3,4,5,7 322:18 323:7,18 326:18 327:8,21 328:1,2,3,7,9,10 333:5 342:13,18 358:20 375:2,5,20 376:6,9 392:18 393:1,7,18,22 394:15,19 395:13
evidence-based 43:8 57:4 59:12 85:7,8 87:14 93:21 114:15,16 294:14
evolve 29:15 131:7
exact 335:12
exactly 45:20 88:15 142:14 276:2 361:18 379:11 386:5 387:16

exam 277:3 280:15 280:16 281:8,15 281:20 282:13 289:13 292:5 293:9 322:17
examination 287:11 291:3 360:22
examine 384:3
example 43:17,19 165:5 175:11 177:18 241:18 243:16 277:4 359:14 386:7 396:3
examples 81:13 253:3
exception 149:15 149:21 182:18,22 183:20 232:19 233:4 262:4 295:21 297:4,10 298:15 299:13 301:22 304:2 328:3,10,13
exchanges 216:3
excited 20:18
excluded 107:7 141:9 354:7 365:1 401:4,5,10 406:8 407:5
excludes 346:18
excluding 399:15 407:13,17
exclusion 84:11,18 106:22 407:11
exclusionary 281:13
exclusions 103:21 150:15 192:4 332:14 399:22
excuse 14:6 122:8
Executive 13:5 16:3
exempt 66:9 149:4
exempted 147:2,2
exercise 151:21

exist 54:5 59:10 60:16 407:1
existed 53:15 134:15
existence 98:21
existing 31:18 57:15 58:4 389:1
exists 57:6 84:17 85:12 159:12 276:21 318:10
expansions 115:7
expect 8:8 273:13 273:14 276:22
expectations 23:12 164:19 165:1,8
expected 24:22 25:9 39:6
expense 140:3
experience 34:10 39:8 88:15 120:8 120:9 135:18
experienced 22:1 164:15 398:13
experiencing 389:16
expert 8:12 17:12 18:15 88:12 182:17 280:10 291:10 298:5 302:6 303:7 350:8
expertise 20:12 88:14 341:2
experts 302:4 340:6 374:16
expired 9:11
explained 299:8
explanation 165:21 167:19 206:8 379:20
explanations 119:18
explicitly 52:19 301:21 338:8
explore 21:4 46:10
exploring 47:14
express 327:13,18
expressed 33:2

73:22 75:8 76:6 84:13,22 87:10 89:8
extended 282:10
extensive 329:4
extent 115:3 158:2 286:18 290:19
external 29:13
extraordinary 166:5
extrapolate 284:2
extrapolated 97:11
extremely 255:21 258:12
extremes 111:22
eye 78:21

F

fabulous 22:9
face 195:17,22 333:9,19,22 334:5 335:19,20 336:18 337:6,11 338:5
faced 95:13
faces 20:1
facility 346:19 354:6
facing 95:18 306:10
fact 120:12 177:11 177:17,22,22 178:10 206:15 218:12 233:12 234:16,19,22 244:12,17 247:8 247:20 251:2 261:5 274:20 278:5 291:7 301:17 351:11 358:2 379:9 380:8 381:4 385:15
factor 117:5 159:3 190:6
factors 33:21 138:3 138:4 168:17 217:6 228:20 233:17 367:12

377:9 380:19
faculty 319:8
failed 187:6 297:7 362:12 363:5
failing 247:14
fair 43:9 112:4 134:13 375:15
Fairfield 367:9
fairly 67:12 76:17 78:15 80:15 206:13 216:21 233:10 235:6 243:19 244:13,18 246:4 253:5 264:12 310:18
fall 21:21 57:12 107:17 111:3 226:1
fallen 357:18
falling 214:11
falloff 326:13
falls 298:16 303:19
familiar 20:1 29:2 49:10 70:4,7 304:16 364:2
families 3:13 47:18 50:3,16,19 51:4 62:18 91:14 380:11
family 1:14 10:6 48:7 50:2,8,13,17 51:7 53:20 54:18 54:20 66:21 81:14 98:22 110:2 178:11 329:10 347:5 377:3 379:10 385:14
family-centered 54:18
far 17:18 21:22 52:17 97:18 100:12 105:10 158:12 276:22 332:7 333:7 342:12 392:18
fast 177:6
faster 384:7,9

397:10
fault 363:16 365:3 365:5
favor 292:1 314:21 315:4 344:12 345:1 388:14
favorably 236:13
feasibility 27:17 38:18 99:21 105:6 152:21 153:17 154:16,17 155:2 155:11,13,18,21 167:8 193:3,7,17 198:6,9,17 225:15 226:4,6,20 227:2 229:16,19 248:19 249:4,6,9 250:16 266:15 267:2,5,9 310:11,17,20,22 311:4,7 321:11 341:18,19 368:22 404:11,16,19 405:2
feasible 154:20 227:20 248:20 321:15
features 322:9
February 40:9
federal 63:11,16 78:11 348:9
federally 12:2
feedback 29:14 61:2,9 173:17 314:8 315:7,8 333:21
feedbacks 333:20
feel 101:7 150:3 171:7 173:19 206:14 207:12 236:14,19 252:7 257:11 291:4 292:7 300:15,17 304:14 313:10 342:20 374:14 379:14 398:11
feeling 206:7,18 257:13

feels 270:14 294:19
fellow 19:3
felt 51:1 52:16 54:2
186:22 189:7
206:10,16 350:12
FEMALE 34:14
73:8 180:12
298:19 315:19
321:6
fewer 35:18 376:18
fidelity 406:19
field 30:10 131:13
228:6 230:11
fields 103:8 332:21
fight 94:4
figure 46:14,15
145:12 196:5
255:10 370:15
371:5,13 378:19
figured 213:1
filing 130:9,11
filled 131:13
212:19
filter 130:2,6
131:21
final 42:13 63:6
158:17 161:18
170:1 204:10
258:17 302:5
304:12 334:6
339:21 344:1,3
finalize 337:5,7
finalized 340:3
finalizing 53:22
finally 21:20 27:18
405:5
financial 8:1 114:7
financing 239:15
find 11:20 137:14
149:13 157:7
158:15 176:7
251:11 254:19
255:13 258:13
335:11 370:12
383:16
finding 118:1,2,3
fine 45:22 213:17

243:5 284:13
388:13 407:6,7
finer 286:22
finish 408:18
fire 305:20,20,20
first 10:21 21:18
26:7 27:6 31:9,9
31:11 32:11 41:14
47:18 48:1 51:15
51:22 57:13 58:11
63:20 71:3,19
75:10 76:5 92:22
94:1 96:8,13
98:14,16 99:13
129:17 137:8
141:18 149:11
162:14,18 179:17
180:17 183:2
188:21 194:19,20
195:8,9 196:20
206:5,17 215:19
241:7 252:15,20
261:21 276:6,13
279:12 281:21
285:7,10 297:13
300:9,21 305:12
312:7 319:4
338:15 343:21
345:13 346:11
351:11 352:19,20
352:21,22 353:3
366:22 368:10
375:20 385:20
391:12 394:12
fiscal 114:6
fishers 97:5
fit 45:6 177:15
368:14
fits 320:7
five 33:15 72:16
93:1 114:17
146:18 154:5
164:4 182:21
191:19 219:7
243:18 344:18,19
348:13
fixed 251:11

flagged 118:6
flights 390:19
flip 380:5
Floor 1:8
Florida 89:20
233:19 245:4
249:14
flow 143:12 175:20
333:1
fluids 376:18
fluoridating 95:16
fluoridation 91:7
91:11 94:5,8 95:7
95:9
fluoridationists
94:6
fluoride 4:9 91:21
207:16 208:5
209:7,10 211:7
213:12 219:4
220:21 223:7,21
224:15 231:3,18
234:22 259:4
274:9,10 308:3
fluorides 93:22
209:7 223:2
231:10 238:18
focus 20:19 50:13
50:20 52:7 56:7
58:22 123:6 136:1
210:22 215:10
222:14 239:20
286:1
focused 26:2 33:10
50:9 64:17 86:21
96:6 241:4 260:18
265:11 316:16
333:11
focuses 33:11 110:3
218:14
focusing 30:21
55:21 56:16
folks 49:18 72:7,16
72:22 155:11
163:15 164:15
172:19 183:7
196:19 210:7

257:11 269:10
276:21 389:9
390:4,19
follow 168:6 175:5
177:7 195:9 207:7
276:4 287:15
328:17
follow-up 64:4
followed 26:8 27:1
85:6 201:14
286:16,18 324:20
following 34:19
66:4 96:12 232:2
302:20 316:21
333:5
follows 44:15 127:6
142:8 210:22
308:2
followup 282:20,21
footnote 84:17
129:22
force 51:6,11 59:16
63:14 203:22
224:12 255:7
forces 11:9
foregoing 72:19
154:8 205:17
269:14
foresee 365:2
forget 163:4
forgetting 163:6
forgive 364:2
forgot 110:22
forgotten 15:20
form 7:10,15
134:16 187:16
212:19 219:17
225:8 242:8,9,11
270:12 288:6
302:1,13,18 330:9
336:3
formal 71:1 339:7
339:17
formalized 165:1
formed 283:21
formerly 14:13
forms 89:7 154:14

203:8 231:5
397:19
formulate 84:2
forth 85:5 178:13
186:19
fortunate 23:18
forum 1:1,8 105:1
247:21
forums 85:11
104:21 203:8
forward 27:9 33:1
33:6 42:3 44:1,19
56:1 59:7 78:17
79:2 80:11 86:1
89:2 90:10 94:18
196:16 209:2
220:19 257:5
271:11 286:14
297:7 298:20
300:8 303:20
304:6 365:15
Foster 67:7
found 58:7 93:13
121:9 170:13
210:19 243:11
259:9 264:17
277:20 329:9
333:15 334:11
338:1 393:11
foundation 1:15,19
2:4 10:13 16:16
189:1 275:8
foundational 31:12
four 34:15 98:16,17
98:18 101:21,22
102:1,1 114:9
124:1 128:6
146:13 150:20
151:8 153:10,17
153:20 156:2
160:9 182:21
184:7 185:9,15
191:5 192:10,15
198:12 199:20
201:19 212:4
264:7 267:10
326:2

frames 236:7
framework 32:7
    142:7 276:4
frameworks 28:11
    287:2
France 1:17 12:10
    12:11 39:5,5,13
    124:13 136:16
    157:6 238:21
    293:17 312:21
    394:1 403:8,18,22
Francisco 122:12
frankly 259:10
    381:15
Frasier 11:1,5
    46:12
FRAZIER 1:18
    313:3 314:1
    370:10
free 173:19
free-for-all 374:18
frequencies 131:4
frequency 317:9
frequently 220:21
front 21:13 24:5
    64:18 65:22 70:16
    70:17 74:1 124:3
    146:2 147:16
    172:20 360:3
full 6:12 25:10,12
    99:13 100:1 147:7
    271:7,19
fully 94:19 212:17
    214:6
function 129:10
    402:2
fundamental
    267:19
funded 109:4
funding 16:10
    39:21 40:1
further 56:16 68:7
    100:7 116:7
    148:22 215:9
    231:21 235:8
    236:8 247:16
    249:20 250:12

257:18 263:21
264:18 266:4
267:2,20 295:16
309:22 310:19
311:15 314:20
315:21 318:17
320:5,7 326:18
327:20 329:12
330:12 331:10
334:12 337:12
343:9 392:20
398:17 403:6
408:1,16
future 24:20 45:13
    78:22 88:11
    118:22 240:10
    254:16 301:16
    365:16
Future's 88:6
Futures 230:3,9
    295:8,13

_____

G

g 129:10
gambit 271:4
game 43:9 139:5
    336:11
gamut 271:8
gap 28:21 53:19
    65:19 85:18 98:8
    99:10 115:17
    121:11 126:18
    128:1 184:2 196:8
    208:22 234:5
    262:22 263:4
    307:6,9,13 329:3
    329:13 330:13,16
    330:20 394:22
    395:7,11 397:7,22
    398:2,6
gaps 32:22 178:17
    234:10 334:10
gastroenteritis
    3:17 71:20 346:12
    346:15,17,21
    349:11,22 350:3
    352:20,21 353:1,5

355:13 368:3,18
368:21 369:2
372:20 375:10
377:13,20 378:1
385:9 389:17
391:12 392:5,8,9
399:13,14,18,19
406:7,8,10,21
407:1,3,17,20
408:10
gastrointestinal
    346:20
gateway 261:1,6
    263:15
gathered 199:3
gathering 364:5
gauged 333:19
geared 347:9
gearing 118:10
Geisinger 1:21
    10:16
gel 225:12 231:14
gender 400:14,20
general 2:8 5:10
    15:19 47:7 68:21
    154:19 170:18
    260:17 292:14
    359:8 393:5
    407:21
general's 82:11
generally 91:21
    115:14 222:18
    223:10 252:13
    254:8
generate 21:17
generated 155:18
    198:6 276:13
genie 389:7
geographic 98:22
    233:17 348:5
    383:19
geography 329:9
Georgetown 2:3
    319:8
getting 144:19,20
    168:2 170:18
    205:22 214:20

215:4 217:2,3,4
226:7 277:21
289:14 290:1
292:17 300:16,18
301:7,13 322:14
324:13 384:4
408:14
GI 398:14
gird 390:17
give 28:10 35:8
    49:9 74:3 76:15
    97:3 113:9 136:14
    159:5 165:22
    166:15,17 169:3
    201:11 203:9
    208:14 213:9
    271:4 302:14
    314:8 347:3 349:9
    350:4 357:22
    375:17 392:2
given 30:4 60:14
    75:21 151:13
    239:20 266:2
    284:1 301:16
    374:22
gives 102:8 317:12
giving 112:18
    171:20 227:10
    231:10 319:11
    401:21
glad 46:20 74:18
glancing 375:12
glean 368:5
global 79:16,18
go 8:16 12:5 19:8
    19:10 22:12 23:11
    26:19 38:14 39:18
    40:17 49:6 56:2
    58:10 59:11 62:7
    70:12,20 71:3
    72:9 73:1,11,12
    74:1 75:22 85:21
    86:18 87:16 90:17
    91:2 95:17 97:20
    99:2,12,18 100:4
    100:6 101:14
    103:12 105:20

106:20 111:13
112:1 116:12,12
123:13 128:13,19
139:1,15 140:21
142:17 144:18
145:16 148:3,9,22
149:11 152:20,22
153:2 155:9,12,15
158:9 162:16,21
163:3,4,8,9,9,10
164:21 166:4
167:2,6,8,9
173:22 176:4
179:16,20 180:2,3
180:8 182:9 187:3
187:19 191:14
200:8,9 201:11
205:3,22 207:5
213:11 224:4
225:18 227:10
228:3 232:3
239:12 240:4
254:7 256:6
260:12 284:9
285:14 293:16
297:6,12,20 298:3
300:15,17,22
304:7 319:6
328:22 335:4
336:4 339:2,7,17
344:4 356:5
360:14 365:22
369:12 373:11
379:18 386:6,14
390:6 391:1,14
394:13 400:6
401:1 408:15,17
408:19
goal 110:4,12,17
    123:16 185:5
    370:19
goals 22:17 37:13
    58:22 59:18
goes 42:4 43:7
    61:11 126:16
    130:12 142:17
    174:2 175:6

176:11 193:3
194:10 220:4
241:18 273:2
300:22 354:11
383:5
going 7:7 9:14,17
15:17 21:2,4,15
22:20 23:8 26:17
28:2 39:9 40:12
43:16 44:19 46:11
49:5 55:20 57:11
61:17 68:18 72:7
72:8,12,13,15
73:1,4,5,11,11
76:9 77:11 79:2
84:4 87:19 90:16
91:2 99:7,12
110:16 116:10
123:4,13 127:13
129:13,14 134:4,9
135:4 138:7 139:1
139:9,11 140:5
145:17 157:18
163:1 166:11
174:8 175:9,21
179:4 186:1,6
197:20 203:14,21
205:14 214:8
222:7 226:21
227:9,13 228:15
229:1,3,10,15
232:6,7 238:20,22
243:20 247:6
254:19 257:5
269:8 273:16
274:11,13 284:22
285:5,6 291:6
292:1,11 296:20
299:21 303:19,20
304:5,5,8 314:11
314:13 319:10
321:15 322:7
324:15 342:2,7
346:11 356:20
358:18 360:15
363:22 365:11,15
366:5,9 384:7,9

384:17,18 386:9
390:19,22 406:14
good 5:4 9:2 10:15
11:2,3 12:10,20
13:3,18 14:9 15:3
15:18 16:6,14
17:14 18:2 19:18
20:10 22:11 38:5
45:16 47:22 58:2
64:1 99:16 114:13
121:14 124:12
169:15 195:19
206:14,21 210:19
226:7 229:10
235:6 238:13
252:8 268:16
271:5 278:9,19
294:11,22 300:15
304:13 319:18
322:5 324:2
326:22 327:2
328:16 333:17
375:6 379:6
380:20 389:11
396:18 402:16
406:19 407:6,7
408:17 409:2
gosh 182:8
gotten 158:20
government 57:17
217:14
governmental
61:12
Governments
95:13
GPP 318:1
grab 374:19
graded 97:10
182:13
grades 318:1
grading 297:19
318:4,5
grant 7:20 16:10
60:15 109:4
grantee 11:8
granularity 373:13
grappled 43:2

grappling 187:20
grasp 121:8
gray 174:13 313:19
great 10:1 22:1,6
22:10 29:19 43:5
43:22 47:21 55:14
62:3 68:16 70:3
71:15 78:22
128:13 174:19
196:3 197:16
214:22 257:3
334:9 344:13
347:2
greater 358:4,5
ground 22:12
25:16
grounded 348:18
group 18:1 20:19
25:4 50:4,13 53:2
53:14,18 54:17
59:15 62:4,8,8
70:22 78:9,9,15
85:4 86:19 133:10
170:17 173:1
177:10 178:9
196:1,4,17 197:13
197:16,19,21,22
210:16 214:14
215:13,13 219:14
222:21 224:4,20
225:22 227:22
230:1,22 231:3,9
237:19,20 240:20
256:16,16,21
264:17 265:8
291:13 332:4
334:2 344:2 347:8
361:22 395:9
400:18
groups 49:14 57:1
66:21 80:4 86:5
94:17 110:9 128:4
184:5 219:9
222:17 227:8,16
227:19 280:4
286:19 287:3
374:6 382:18

growth 226:11
283:20
guardrails 44:6
guess 44:14 68:13
98:2 105:18
128:20 136:16
147:13,15 168:22
208:11 213:21
218:1 219:15,21
230:21 236:17
237:9 252:1 273:1
273:15 275:10
277:10 284:15,17
287:19 288:4
289:13 297:14
298:18 313:3
316:4 324:4
357:21 358:7
386:15 387:1
388:10 393:17
guest 6:10,11
guidance 25:21
31:20 45:11 78:1
127:11 169:16
171:20 172:11,15
183:3 187:22
188:14,16 189:8
189:17,19 252:5
283:20 357:22
373:18
guide 3:14 41:21,22
47:20 48:11 60:22
61:7,11 67:18
68:7,8 106:13,15
120:4 130:1,14
185:20,21 216:3
374:9
guided 56:22
guideline 11:12
87:3 88:6 96:18
97:2,3 182:14
230:3 247:11
317:12,16
guidelines 14:1
85:7,8 87:14 88:4
93:5,9 114:15,16
150:4 207:7

208:19 209:11,14
218:10 220:12,16
225:3 230:9 231:2
236:17 237:6,8
240:6 248:2 284:1
284:5,6 295:9
303:8,11 317:5
377:20
guys 129:8 135:8
288:8 326:21
342:8

H

H 66:6
habit 283:21
Haines 92:13,14
half 205:16
halfway 408:20,22
409:1
Hammersmith 2:8
3:6 5:10 7:5,6
18:18
hand 64:19 71:4
146:1 315:1,3
handle 104:12
hands 22:6 315:2
385:22
happen 13:13 40:4
230:12,17 244:5
244:22 289:2
300:20
happened 155:4
354:16
happening 29:9
137:9 140:16
239:4,9
happens 21:20
195:6 238:7 323:2
323:9 324:19
354:14
happy 61:8 68:12
260:8 341:3
hard 101:18 151:17
152:10 160:19
172:13 408:13
harder 368:19
380:10

hardest 162:15
harm 256:8
harmful 231:11
harmonization
27:20 33:1 55:11
65:20 178:18
237:21 238:3,11
harmonizing 239:8
harms 231:5 298:7
Haven 367:7
HDR 382:15
headings 35:10
health 1:3,15,21,21
1:22 2:2,4 3:11,13
3:14 5:7 10:17,17
11:16 12:2,12
14:13,14,16 15:6
15:11,13 16:4,8
16:15,17 17:15,21
18:4,6 22:3,5 23:7
28:12,22 29:2,3,8
30:15 31:6,8,14
31:16,21,22 32:4
32:4,8 33:13,19
34:6,17,20,22
35:6,10,16,18
36:12,13,15,16
37:3,6,7 38:22
41:12,14 42:1,19
43:13 44:11 46:4
47:19 48:2,4,7,10
48:15,18 50:13
51:7 52:6,13,18
52:20 53:9 54:13
55:1,9,22 56:6,20
57:5,10 58:9 59:1
59:9 61:12,15,17
62:9,19 63:1 65:2
66:3,10,19 67:10
76:8 77:13,22
80:5,8 81:1,21
82:6,12 83:5,12
84:7 89:2,21 93:2
95:8 96:11,16,16
108:3,9 109:21
111:13,16 115:13
120:15 123:16

126:8,10 139:4
142:11 143:17
154:22 172:8
182:2 185:4
187:22 188:4,16
188:22 189:11
190:1 197:1
203:17 210:12
212:16 213:3,15
226:2 233:12,13
239:18 259:16
261:6 262:15
264:15 265:10
271:19 273:10,19
273:22 274:1,3,12
274:14,18,21,22
275:7 276:16
277:11 283:22
285:19 287:13
289:5,7 290:2,19
292:19,21 297:21
316:21 317:3,3,15
317:18 321:1
323:12 358:4
359:9,12,16 362:8
362:15,20,21
363:1,3,10,11
364:10,11 365:2
367:11 369:15,16
370:11,16,20
371:2,4,8 378:17
378:20 379:8
380:4,6 384:1
386:7,11,12
393:14
healthcare 2:14
18:11 36:20 45:21
52:7 110:11 112:8
112:10 123:17
132:3 138:6 142:9
185:6 189:10
272:3 275:20
293:12 307:20
308:1 348:1,7
361:15 362:10
369:17 370:1,5
372:6,7 389:14

396:2
healthier 273:9
healthy 1:18 11:5
30:19 31:3 33:11
34:21 55:20 142:7
276:8
hear 42:6,11 44:7
76:14 89:15 157:8
169:8 170:4
238:14 252:1
257:10 273:1,10
288:12 315:6
349:14 389:9
393:17 407:15
heard 46:2 113:7
114:1 197:6
hearing 227:5
280:8 314:20
387:18
heart 70:10
hearts 34:5 85:22
heavier 41:1
heavy 380:15
HEDIS 83:17
279:10,18,20
294:8
held 213:3,5 246:4
252:17
Helen 2:7 19:17,20
28:5 30:13 42:5
44:15 162:13
289:15 382:3
383:11
Hello 5:3
help 21:4 51:12
63:9 66:1,21
86:11 91:6,8
113:15 116:11
129:4 132:10
133:9 165:9
171:11 181:8
196:14 201:22
209:1 217:7
247:13 290:18
304:14 371:19
helped 84:2
helpful 164:14,19

165:5 175:22
178:7 276:20
292:9 382:4
383:14 393:8
helping 165:13
helps 144:11
305:22 306:6
326:4 355:17
Herndon 2:13
89:19 176:22
hesitate 312:21
hey 390:2
HHS 216:4
Hi 8:19 10:10 12:6
15:9 117:3
hiding 256:20
high 27:5 51:2 53:3
63:20 86:5 91:17
93:13 94:17 95:2
96:7 97:17 99:1
99:19 100:13
105:6 108:16
113:2,6 117:16
118:4,7 123:14,17
123:21 125:20
126:16 127:7,8
128:5,14 132:9
136:22 137:16,17
138:10,15 146:10
146:17 150:19
151:6 152:13
153:9 156:1,11
160:8,13 167:12
169:2 172:20
176:19 182:5,12
182:19 183:17
184:6,12,22 185:3
185:5,8,14,14
186:22 187:7,10
191:4,19 192:9,15
195:15 196:17
198:11,18 199:19
200:4 208:4
209:17 211:14
219:1 220:22
231:10 232:16
233:1 234:6,11

235:7,12,13,17
236:5 246:13,18
246:21 248:8,10
249:6,10 250:2,7
258:11 262:2,8,22
263:5 264:3,7,21
265:4 266:8,12
267:5,10 268:2,8
295:19 296:4
303:1 307:9,14
308:9,10,16,17,22
309:7,12 310:4,9
310:22 311:5,18
312:1 318:8 328:1
328:7 330:16,20
331:2,12,13,17,18
334:16,20 336:17
336:22 337:16,19
338:15 341:20
342:4 343:13,18
363:15 372:21
397:13 398:2,6,15
398:20,21 399:5
402:8,13 404:4,8
404:19 405:2,16
405:21
high-quality
347:15
higher 95:3 100:17
151:16 264:2
331:5 355:12
367:8 380:9
381:12 382:1
397:10
highest 396:4
highlight 185:21
highlighting 93:20
217:9
highlights 100:10
165:18 166:15
historic 228:10
291:14
historical 291:10
350:5 361:3
historically 44:19
90:10 197:22
223:1

history 86:13 113:18 118:21 121:3 131:21 134:10 136:2 181:6
hit 92:1 124:15,18 166:6
hitting 269:5 356:6
HIV 36:2
hold 112:4 146:21 298:10 362:19
holding 256:12 386:12
home 93:15,15 230:20 270:15,18 271:13 286:3 316:1 319:6 327:15,16 353:16 354:21 356:5
honest 373:16
hope 28:7,17 164:2 164:18 190:15 325:14 361:7 409:19
hopeful 39:22
hopefully 21:4 39:3 68:7 69:1 74:2,13 94:2 131:2,6 140:17 142:22 145:2 168:7 207:11 208:22 257:4 323:2 346:8 383:20 408:16
hoping 28:9 29:1 29:12 39:2,22 41:17 196:11 230:18 318:20 339:11
hospital 18:5 50:21 51:16,17 52:4 63:11 67:7,10 347:20 348:6,11 351:20 352:2,5,8 352:9 361:13 363:6 367:19 375:7 376:13,18 381:11,22 385:7

385:17 398:15 401:9,16 403:15
hospitalization 355:13 356:3,12 357:17 360:17 377:11 386:5
hospitalizations 347:12,22 350:13 360:13 403:16
hospitalized 396:12
hospitals 52:8 348:12,19 360:10 364:22 365:4 367:17 376:16 378:19 389:21 401:13 403:10,12
hour 21:19 205:16 403:4
hours 61:6 352:1 356:5
house 385:12
household 376:3
housekeeping 5:13 104:17 409:3,16
HQR 382:15
HRSA 57:17
huge 42:21 85:18 91:20 111:14
huh 319:17
humans 138:7
humbly 19:8
Humphrey 76:19
hung 345:13 387:12
hydration 403:1
hygienist 102:16 106:7 107:1,8
hygienists 81:16 83:4

_____

I

i's 337:8
i.e 100:18
ICD-9 399:12
idea 20:15 289:16 336:18
ideal 69:10 112:9

ideas 30:10
identification 317:1
identified 53:18 196:2,9,17 209:16 218:22 263:13 336:12 338:6 350:14
identify 28:21 86:19 181:4 196:1 197:12 293:10
identifying 186:20 309:1
ignore 130:2 332:1
illnesses 347:18
illustrated 67:14
image 248:3
imagine 289:6 300:9 313:8 386:3
immature 257:12
immediate 8:21
immediately 79:4
immersed 77:14
immigrants 94:16
immunization 32:14,21 33:8
immunizations 53:8 212:12
impact 9:4 42:22 116:17 123:15,17 123:21 126:17 166:6,19 185:6 226:6,21 248:5 254:12 301:20 360:8,19 369:15 369:15 370:15 371:15 382:11 402:20
impacted 320:11
impactful 77:5
impacts 46:17 226:12 229:15 369:9
implement 78:1 116:5 226:4 341:15
implementation

102:11 131:7 376:15
implemented 86:9 105:17 122:5 148:2 153:21 155:20 198:8 342:16 360:1,6
implies 363:1
imply 363:2
importance 32:2 36:6 38:15 85:17 93:20 99:11,21 105:22 116:14,21 123:7,9 127:22 149:11 166:17 181:12 232:13,14 234:4 235:11 291:4 297:8 318:10 327:9
important 18:21 21:14 27:7 28:14 29:6 36:9 47:5 54:22 58:8 86:14 89:1 90:9 92:5 93:1 102:6 113:14 118:22 131:1 168:19 173:3 175:4 218:22 232:4 234:20 238:10 253:13,19 254:4 257:1 258:12 275:1 288:1 289:4 319:5 361:20,21 363:14 363:19 365:13 370:8 381:3 384:16,20
impression 91:10 397:18
improve 23:12 42:1 52:12 56:20 57:10 105:16 130:19 196:14 317:18 342:14 350:11 378:16,20
improved 142:10 166:1 273:19

274:18,22,22 317:3
improvement 24:19 31:22 32:5 32:9 59:9 60:8 61:16 63:18 70:3 85:21 130:18 137:4 153:8 158:5 159:1,18 160:4 166:19 190:16 199:15 233:6 244:2 249:18 251:1 262:13 274:12 275:7 290:2 306:17,20 307:6 311:13 368:16 379:8 381:17 383:13 386:18 395:2,3 405:10
improvements 24:21 57:5 58:9 59:11
improving 48:14 96:16 110:13 188:3 190:1
in-person 39:14,19 40:3,10 41:4 104:21
inappropriate 65:5 164:3
incentives 57:6 133:18 143:16 144:1
incidences 292:12
incidents 91:22
include 32:7 34:19 37:21 81:14,22 102:19 112:20 132:22 248:3 250:18 353:5
included 31:12 35:9 37:3 63:5 83:4 196:19 227:7 283:7,8 318:14,15 336:11 339:6
includes 322:13

348:12 362:15
including 6:5 14:1
  33:22 36:20 75:3
  77:22 78:11 83:1
  146:6 150:12
  191:1,22 210:6
  274:2 330:8
  348:14 375:22
  377:12 405:7
inclusion 77:21
income 94:14 98:22
  329:10 376:4
  382:20 396:4,4
  397:10
incomplete 401:18
  401:19,20
inconsistent 313:11
incorporate 58:3
  231:8
incorporated
  122:21
incorrect 340:12
increase 92:15
  134:2 141:11
  143:18 221:14
  244:14 256:13,18
  256:19
increased 355:4
  395:22 396:14
increases 144:5
increasing 383:18
incredible 90:7
incremental 244:14
  289:21 301:13
incrementally
  287:21
incubator 30:9
independent
  102:15 217:16
  255:8
independently
  201:4,9
indicate 26:4
indicated 77:2
  167:1 272:7
indication 269:9
  311:11

indicative 118:19
  119:21
indicator 143:4
  144:10 247:9
  254:19 267:17
  271:5,12 287:12
  345:21 347:8
  377:16
indicators 15:14,15
  15:16 34:22 35:15
  36:16 37:6 54:4
  65:3 86:14 347:6
  347:9,13 349:19
  350:6,9,10,21
  357:7 360:7 361:1
  372:14 374:12
individual 8:11
  46:16 52:3 94:22
  113:3,12 140:15
  140:18 186:4
  194:18 195:6
  203:9,13 204:2
  222:12 326:5,6
  372:2 381:10
  388:2
individually 186:3
  200:15 203:20
individuals 57:1
  63:17 93:10 94:14
  94:15 138:11
  143:11 193:13
  197:6 218:22
  233:21 320:18
indulging 74:8
industry 348:9
inefficient 147:11
Infectious 36:4
influence 86:10
  140:19 257:16
inform 66:1
information 49:3
  68:3 101:1 127:4
  127:12 130:14
  135:20 153:11
  160:16 187:14
  200:6 227:18
  245:12 249:17

250:3,9 262:14
  263:10 268:3,10
  289:19 290:1
  293:5 302:17,18
  304:3 310:17
  311:19 312:3
  314:15 343:14,19
  368:4 396:21
  405:17 406:1
  409:14
informative 29:10
informed 17:12
  30:16 31:9 36:11
  295:4,8 390:11
infrastructure 80:1
  95:12,15
Inge 1:18 15:18,19
  129:15 131:17,22
  136:4 179:8,22
  180:7,10,15
  181:20 184:19
  186:15,18 189:14
  193:10,22 199:4
  231:14 275:2,5
  276:20 277:19
  280:20 281:15
  282:21 283:2
  292:10 306:19
  307:16 308:19
  309:14 310:11
  311:8 344:5
inherent 227:21
  271:14,21
initial 37:19 55:10
  77:1 116:13 212:2
  282:19
initially 78:8 134:7
  336:7 339:4 349:4
initiative 11:10
  143:17 374:11
initiatives 372:12
inner 120:1
inpatient 347:19
  348:11 355:12,20
  356:12
input 23:13 29:13
  49:3,8,14 63:22

68:11 74:3 78:16
  252:22 312:18
  364:5 384:21
inside 89:6
insight 28:10
  131:17
instance 63:15
  64:11 108:9 159:2
  274:9 277:1 278:3
  280:7 364:15
  373:1 375:8
instances 373:7
institute 2:1 12:8
  14:12,12 16:4
  17:20 31:14 89:21
  90:1 120:14 400:9
Institutes 55:8
institution 66:8
institutions 399:16
Instructions 3:5
insufficient 124:1
  127:12 128:6
  146:12,19 147:1
  148:14,20 149:2
  150:20 151:8
  153:10 156:2
  159:3,6,7 160:9
  160:16 169:4,5
  182:18,19,21,22
  183:19,20 184:7
  184:14 185:9,16
  191:5,21 192:10
  192:17 198:12,19
  199:20 200:6
  232:17,18 233:2,3
  234:7,12 235:14
  235:19 246:14,19
  248:9,12 249:7,11
  250:3,9 262:3,3
  262:10 263:1,7
  264:4,9,22 265:6
  266:9,13 267:6,12
  268:3,10 295:20
  295:20 297:3,4,10
  298:15 301:22
  304:3 307:10,15
  308:11,18 309:8

309:13 310:5,10
  311:1,6,19 312:2
  328:2,2,9,9,12
  330:17,22 331:14
  331:19 334:17,22
  337:17,21 341:21
  343:14,19 398:3,8
  398:22 399:7
  402:9,15 404:5,10
  404:20 405:4,17
  406:1
insurance 111:7
  112:11 115:13,14
  115:16 139:18
  215:15 329:10
  403:4
integrated 32:7
  154:22 332:22
integrates 33:4
integration 80:5
intended 50:3
  154:21 172:22
  373:19 381:7
  382:2
intensity 223:8
intensive 219:3
intent 63:8 84:11
  84:19 104:9 147:7
  327:14 358:15,22
  374:20
inter-rater 103:9
  187:11
interaction 138:21
  139:10 195:3,7
  230:11
interactions 25:8
interest 3:5 5:12
  7:22 8:2 18:22
  319:2 350:15
interested 7:19
  49:7 214:16,17,19
  373:16 385:2
interesting 21:3
  43:11 51:5 317:20
  361:6
interim 314:10
  340:1

intermediate 127:3
232:16 262:1
297:22
internalize 173:4
International 9:4
internist 16:8
346:5
interpret 171:12
201:1 275:21
300:8 390:5
interpretation
174:7 322:22
interpretations
174:16
interpreted 239:6
357:3 358:1
363:18 364:8
interpreting 188:8
interrupt 9:13
interval 293:19
294:3,5 317:10,12
317:13
intervals 318:11
intervention 86:20
88:10 222:11
294:14
interventions 35:1
57:9
intravenous 376:18
378:1
introduce 6:18
23:20 69:20 70:13
72:12 73:12 74:10
246:7 318:22
introduced 73:3
135:15 307:19
introducing 166:10
introduction 3:7
19:16 24:7 134:17
307:22 320:1
introductions 5:12
7:8
involve 380:2
involved 14:22
56:12 57:13,14
89:16 119:8
156:20

IOM 55:19 57:15
irrelevant 300:1
IRS 66:6
Island 1:22
isolation 49:1
issue 21:5 43:12
47:5 64:5 94:13
102:14 108:2
175:10 178:4
214:15 234:20
235:7 237:14
239:1 254:14
258:8 260:2
263:12,19,19
265:14 306:9
316:9 324:4 332:5
343:2 363:9
364:17 369:18
370:3,8 374:7
375:1 388:19
issues 21:13,15
24:10 28:18 41:3
47:14 103:19
167:14,20 169:18
195:16 240:19
380:10 388:4
it'll 40:17 105:9
315:10
items 5:14
iteration 321:14
iterations 119:10
iteratively 336:4
IV 354:17
IV'd 354:13

J

J.H.M 400:8
Jacki 16:7 71:21
Jacobson 31:14
Jacqueline 1:22
351:6 391:16
JAMES 2:13
Jane 1:17 13:19
156:14 168:9
181:17
Jason 2:2 13:4 99:4
JD 2:8

jeopardy 163:5
Jersey 10:12
Jewish 1:22
Jill 2:13 89:19 90:6
90:13 119:7
134:13 225:7
244:10,22
Jim 272:15
job 138:18 326:22
327:2 409:2
John 1:14 14:10
37:14 62:6 107:19
164:1 168:11
236:9 386:9
John's 369:13
Johnson 1:19 2:3
10:13
Johnson's 11:9
joined 72:4,8
318:20
joint 60:3 78:14
JUAN 1:16
judge 207:8
judgement 140:14
152:2 302:13
383:13
juice 91:16
July 40:14 63:7
jump 51:21 56:13
73:4 75:7 285:10
287:8,8
jumps 242:16
243:18
June 40:13 63:6
justification 389:20

K

Kahn 6:20
Kaiser 1:17 12:12
Kaitlynn 2:10 6:21
116:11 123:9
124:22 145:15,22
146:4,4 153:2
155:16 157:15
158:9 159:20
163:14 180:11
181:16 193:18

198:4 199:10
232:11 235:9
241:11 246:9
249:21 251:16
258:16 261:20
262:20 263:22
264:19
Kaitlynn's 145:17
kappa 176:19
187:7,10 333:18
Katelynn 408:7
Kathy 72:1 205:5
Katie 2:1 15:4
379:19
Kaye 61:21
keep 26:1 94:7
176:9 256:4 292:1
303:20 304:5
325:17 386:14
409:20
keeping 202:1
316:1
kept 46:3
key 58:6 108:18
371:20
keypad 205:10
Khan 2:8 3:9 9:13
10:1 22:11 40:7
68:13 71:22 72:5
104:16 126:19
127:1 147:3,8
159:9 160:22
161:3,7,11 168:1
173:10,21 175:7
182:6 183:1
205:13 246:20
303:16 312:13
313:18 315:2,6
319:10,15 320:3
328:14,17 391:17
391:20 408:3,21
409:4
kick 96:4 196:12
kids 78:4 86:19
112:5 113:9
114:11 115:5,15
115:21 116:3

120:10 137:15
138:12 143:19
144:19,19 196:5,8
214:17 217:1,3
230:13 239:17
257:22 258:10
270:18 347:10
353:17 368:21
396:11
kind 44:2 46:9,11
51:13 65:20 79:16
107:16 110:20
119:3 133:10
149:21 160:18
162:15 165:21
168:5,16 169:6
171:2,4,6,11
172:13 175:8,20
175:21 178:4
219:19 226:1
230:19 235:5
261:6 269:9 276:3
295:9 300:5 302:7
313:14 323:21
339:21 359:18
363:21 365:22
366:4,21 372:12
375:14 382:19
383:1 384:8 387:8
393:7,10
kinds 47:13 235:1
266:21 365:15
kit 228:2
knew 172:11
know 9:19 20:2,5
20:20 21:5,11
30:5 31:1 32:18
37:10 41:8 42:8
42:10 43:18 46:3
56:13 59:4,10,22
61:13 62:1 64:5
65:6 66:5,6 68:20
69:10,13 70:6,14
75:5 78:22 79:5
81:2,5,6 82:8,12
82:15 83:16 87:5
89:8 90:8,17,18

91:6 92:19 93:6
94:13 95:14 99:8
99:20 100:5,9
103:22 104:3,12
107:22 108:2,6,9
109:2,9,19 110:1
113:17 114:6,8,14
116:15 118:14
119:17 120:12,18
120:20 121:2
131:11,17 134:5
134:14,19 135:15
137:6,19 138:13
139:3 142:10,21
143:3,21 144:3
148:19 154:12,19
156:19 157:20
158:6,13 159:5
162:13,15 163:4
163:12 164:2,7,14
164:15 165:11,12
165:13 166:3,4,7
169:12 170:12,20
171:7 172:14,15
174:4,11,14,15,17
174:17 178:20
186:6 187:6 188:2
190:19 192:20
197:22 200:12,13
203:14,15 206:22
208:17,21 209:12
212:3,6 213:1
214:6 216:18,20
217:1,13,19,21
218:9,12,20
220:15,20 221:10
222:9,9,22 223:12
223:19 224:9
225:21,22 226:7
226:11,14,18,20
227:7,22 228:8,15
228:17,19 229:6
230:2,4,17 236:10
237:5,22 238:17
240:4 244:10,14
244:16,21 245:1,5
245:8 246:1,1

247:22 251:5
252:6 253:1,15
255:10 256:1
258:10 259:18
260:2 271:3 272:6
272:7 276:11
277:16,19 278:17
279:5 284:14,17
285:4 286:10,17
287:15 290:6,8,12
291:5,22 292:3,7
293:20 294:2,6,10
294:17 295:5,9
301:6 303:9 305:3
305:8,22 306:6
316:5 320:6
321:12 322:16
325:6 326:14
339:20 343:1,4
351:10 353:15
354:3,14,16 355:3
355:5,8 356:4,7
357:17 358:22
359:2 360:9 361:8
362:16,18 364:5
364:12 370:19
371:15,15 375:9
376:5 380:12,16
381:19 382:8
383:14,16,19,22
384:3,5,8 388:5
388:14,16,18
389:5 391:15
392:2 393:6,8
394:8 406:19
407:18,22
knowing 42:7
101:15,16 149:15
150:2 260:9
278:20
knowledge 274:8
346:7,8
knowledgeable
206:19
known 37:17 79:9
81:18 85:19
knows 20:10 45:17

Krishna 2:12 73:8
73:11 76:13,17
77:2 80:10 84:4
92:9 108:18
119:20 121:7
176:7 187:3 190:9
194:3 199:6
Krishna's 89:15
213:22
Kristen 288:13
Krol 1:19 10:10,11
10:20 96:3,5 98:5
98:7 100:12 105:2
105:5 126:13
158:11 194:16
196:18 197:2,5
257:19 272:14
279:14,16 297:9
298:16,21 299:2,5
299:9,12 302:9
304:14 316:15
328:22 329:3
331:2,20 335:1
341:8 342:7 353:8
354:9

_____

L

L.A 31:15
lack 75:11 88:7
318:8
lacked 115:13,15
lacking 54:3 75:14
lagged 115:9,10
landscape 46:17
language 54:13
60:1 84:11,14
104:3 305:11
322:14 332:2
338:1 364:12
389:20 390:3
laptop 161:5
laptops 168:5
large 16:11 90:3
101:12 114:20
189:6 217:8
223:19 225:16
243:19 247:9

256:21 304:16
362:14 397:3
largely 134:10
larger 46:8 306:9
362:16
largest 120:10
289:18
late 19:19 255:10
291:11 319:5
408:13
Laughter 11:21
12:19 16:21 201:7
319:21
launched 76:18
laws 109:6
lead 5:11,11 18:10
68:15 71:1 74:11
171:3 179:4 208:7
272:12 273:8,9,18
275:6 277:11
278:16 323:11
345:20 390:4
leaders 176:6
leadership 58:17
leading 50:11
277:5 363:22
leads 274:3,22
learn 162:16,17
276:21
learned 265:17
learning 20:6
learnings 67:6
leave 18:20 232:8
279:2 312:9
342:22 343:8
Leavens 2:9 3:15
29:5 41:20 47:16
47:21 54:8,15
55:2,6,14 61:20
62:2,15 65:14
66:16 68:10
leaves 351:20 352:1
leaving 342:9
led 32:10 74:16
134:21
left 156:7,8 157:13
189:16 332:3

legislation 115:18
legitimate 290:4
length 334:7
lens 46:7
let's 8:16 65:8
100:21 105:20
109:4 123:6
147:12,19 154:7
186:11 196:3,5
227:6 235:9
249:21 261:20
265:20 267:3,22
268:16 286:1
296:11 307:5
308:7 309:4 310:1
310:20 311:16
327:21 330:13
331:11,21 332:15
334:13 337:13
341:18 343:10
372:2 391:1,14
394:12 395:11
397:21 398:18
400:5,8 402:5
405:14 408:2
letting 73:17 95:16
232:3
level 21:7,8 27:5
31:19 34:22 35:15
36:16 37:6 42:7
44:3,4 46:8 47:1
50:5 51:20 52:2,5
65:1 75:20 79:11
87:22 94:14 97:19
99:19 108:6
110:18 129:1
130:5 131:2,2
135:21 136:3
140:12,18 144:13
145:10 149:19
151:16,17 167:12
189:5 209:6 215:5
253:20,21 275:19
290:2 303:12
311:12,12 321:17
323:7 326:7,8
348:6 355:11

366:4 368:10,11
371:1 372:17
373:8,12 381:4,7
381:20 382:9,22
383:4 392:14
394:9 401:18
leveled 113:13
levels 21:5 36:20
366:6 381:12
382:1
leverage 56:1
leveraged 53:3
liability 186:16
187:11
liaison 14:2,4
licensed 81:10
lies 144:8 355:2,14
life 15:15 31:2
34:19 67:15 93:1
279:12 317:4
lifestyle 31:4 33:11
lift 41:1
limbo 312:6
limitation 75:21
limitations 77:3
272:5 282:7
limited 75:14 85:3
199:5 219:20
274:8 284:1
289:17 317:14
371:22
limiting 215:5
limits 140:13
line 231:1 308:3
lines 67:12 205:5
360:3 368:17
link 276:9
linked 137:5 142:3
276:6
Lisa 302:3
list 15:22 58:5
67:15 142:1 339:4
339:7
listed 9:16 89:6
102:19,20 106:11
118:15 243:1,2
288:8 339:11

listen 61:5
listing 37:3
literacy 54:13
literature 118:21
262:17 330:5
377:15
little 9:15 23:9 49:5
49:9 52:1 56:11
71:5,10 73:4 76:4
76:18 77:15 81:3
91:5,6 105:21
114:1,2 126:5
129:4 141:3 146:1
157:7 158:7 163:2
165:2 168:22
169:8 174:5 177:1
206:6,9,11,16,18
207:12 212:22
222:1 226:13
242:2 252:4
257:14 278:22
286:22 306:3
313:15 362:6
371:18 383:11
387:9 403:20
live 119:20 237:18
306:1
lived 43:12
living 34:22
locality 30:5
locally 367:6
location 233:17
locus 43:14
logic 20:3 86:12,15
87:2 102:17
111:10 130:10
155:22 195:13
198:10 209:19
332:7 349:20
logical 286:15
logically 21:10
353:6
loins 390:18
long 1:22 7:10 42:9
82:19 85:20 91:7
91:7 105:8 113:20
214:13 279:5

292:2,4 305:9,21
334:9 341:9
longer 43:2 217:20
252:13 253:16
254:8 316:9 325:8
326:13 356:11
longest 317:11
longitudinal 121:2
325:15
look 8:1 11:10
14:19 15:14,17
18:12 39:9 55:19
61:7,13 63:20
64:2 78:1 82:2
110:1 113:8
114:14 118:12
119:13 121:10
144:18 173:16
184:20 185:19
204:2 212:1 213:8
214:7 219:13
220:17 223:14
225:2 227:19
229:19 241:15,17
245:13 253:17
254:18 271:7
284:5 287:6,15
294:10 301:21
325:20 326:15,16
360:8 364:3
369:22 372:20,22
373:4,4 374:2
382:16,17,19
383:15 388:5,19
390:9 401:1
403:13 406:15
looked 34:7 57:18
78:16,19 80:16
88:3 107:6 112:15
206:12 252:13
277:21 278:1
285:6,11 286:8
334:8 363:17
375:9 381:21
looking 7:15 13:12
14:18 27:13,20
30:22 31:3 36:6

37:20 47:8,11,12
48:8,12 51:16
52:10 56:17 58:6
58:12,15 60:9
64:10,12 77:16
79:3 94:22 113:17
126:16,17,18
147:8 159:11
179:13 183:2
189:3 197:17
200:14 210:18
211:17 215:2,3
219:16 221:7
222:3 233:6 236:6
238:12,22 242:8
254:1,5,7 257:6
266:1,2,16 271:10
283:15 287:11
294:8 315:21
323:19 326:6,9,12
333:13 338:2
353:11 357:1
358:9,13 371:10
373:17,22 374:1
375:15 378:16
382:8,9 384:6
385:7,18 389:14
395:1,7 399:10,21
403:3,16 406:9,11
407:12
looks 45:2 125:8
144:15 170:19
212:16 214:2
234:14 240:18
271:1 296:3
339:14 352:17
loop 48:21
Los 388:6
lose 112:2 197:14
losing 196:6
lost 180:10 342:3
lot 21:2,15,16,17
45:2,4 56:4 57:16
57:19 59:3 61:1
61:15 70:6 81:5
82:9 111:11,15
112:14 140:3,5

147:21 174:12
176:20 228:15
230:16 237:22
238:6,17 251:9
269:8 280:8 282:8
285:11 286:7
291:20 299:15
322:11,15 323:18
365:21 366:9
368:3 369:13
377:22 386:17
Lots 20:1
lottery 319:17
loudest 173:2
love 20:13 30:2
42:10 46:10
lovely 70:16
low 94:14 113:2
117:15 118:1
123:22 125:21
127:8 128:6,15
134:1 136:9 138:9
146:11,18 150:20
151:7 152:13
153:10 156:2,13
160:9,15 169:5,5
172:21 173:2
182:12,15,16,20
183:18 184:7,13
185:9,15 191:5,20
192:10,16 198:12
198:19 199:20
200:5 231:16
232:17 233:2
234:6,12 235:13
235:18 240:22
246:14,19 248:8
248:11,15 249:7
249:11 250:2,8
262:2,9 263:1,6
263:11 264:3,8,22
265:5 266:8,13
267:6,11 268:2,9
294:2 295:19
297:2 303:1 304:4
307:10,15 308:10
308:18 309:8,13

310:4,9 311:1,6
311:18 312:2
318:16 328:1,8
330:17,21 331:13
331:18 334:17,21
337:16,20 341:20
342:5 343:13,19
367:15 395:14
398:3,7,21 399:6
402:8,14 404:4,9
404:19 405:3,16
405:22
lower 151:17 377:5
377:11 395:5
lowercase 6:10
lowest 396:4
lowly 312:18
luck 1:19 11:22,22
117:3 242:19
301:15 302:20
303:6 386:3
408:15
lucky 10:21
lunch 6:5 205:3,3
205:14,15 206:1,2
218:8

_____

M
_____

ma'am 72:3 205:7
magic 141:19,20
142:21 194:12
magnitudes 243:20
main 24:6
mainstream 272:2
maintain 66:8
130:9
maintaining
283:22
maintenance 26:13
38:8,10 120:6
159:14 237:4
major 35:9 192:19
228:19 229:4
377:14
majority 108:22
109:10 115:21
131:15 135:4

139:7 141:14
292:13 312:9
315:5 406:21
making 22:22
30:18,19 32:2
46:3 58:17 59:11
59:12,21 60:5
186:2 189:8 254:6
254:16 277:13
299:11 316:2
376:7 379:15
MALE 12:17 76:2
190:8 202:17
328:15 385:19
manage 353:16
managed 10:7
management 10:18
61:16 122:10
317:17 353:12,13
353:14 389:16
398:16
Manager 2:8 6:20
7:1
managing 2:10 5:5
218:18 282:11
347:16 353:21
mandate 140:8
manner 19:5
map 3:13 47:18
48:7 49:10,21
51:6,10 59:15
63:9 66:21 388:15
mapping 59:2
maps 388:16 389:5
Marcel 2:1 12:6
287:20
March 40:10
Margaret 1:19
11:22 179:3
marginalize 313:14
marginalized 313:9
marginalizes 313:7
313:12
mark 9:19 215:20
279:4
marker 137:21
270:17 271:22

287:18
markers 376:4
market 367:12
marketplace 78:21
220:6,15
marketplaces
216:3
Mary's 1:19 12:1
Maryland 12:4
masking 141:10
Massachusetts
14:15
material 37:18
38:13
materials 166:13
375:12
maternal 1:19
15:13 53:9
Mathematica
228:1
matter 72:19 107:5
107:9 154:8
205:17 269:14
318:21 325:1
345:8 365:10,10
381:12 403:14
410:5
maximum 139:20
McGaw 67:7
MCH 15:10
McInerney 1:9,12
8:19,20 10:2 22:4
55:4,7 71:14 91:4
95:5,21 184:21
205:20 210:3
211:5,22 214:10
215:8 231:20
232:10 234:2
235:8 236:8 240:5
241:6,9 246:8
247:15 248:17
249:3,20 250:10
251:15 256:5
257:3 258:16
259:7,12 261:19
262:19 263:21
264:18 266:4

267:1,20 268:11
269:4,11,17
272:11 275:4
279:4,15,17,22
284:3 292:22
293:15 295:15
300:3 306:12
307:4 308:6 309:3
309:22 310:19
311:7,14 312:4,20
314:20 315:3,11
316:14 318:17
319:19,22 320:4
320:17 325:2
326:17 327:20
328:11 329:2,12
330:12 331:1,10
334:12 335:9
337:12 341:17
343:9,20 344:7,10
344:19,22 345:6
345:11 346:10
349:15 351:4,8
352:15 355:22
356:16 362:2
371:17 377:17
383:10 388:8
390:8 391:9,19,22
393:3,21 394:7,21
395:10,16,19
396:20 397:21
398:9,17 399:8
400:4 402:5,16
403:6 404:1,15
405:13 406:2
408:1,12 409:1
McKane 1:20 15:9
15:10 174:2
193:19 194:1
325:3 329:14
330:11
MD 1:12,12 2:9
3:15
MDCH 15:12
meager 135:14
mean 11:19 43:6
54:15 89:15

133:11 143:16
169:20 173:3
179:19 188:7
200:17 214:5
219:7 221:13
238:16 244:3
253:13 255:9
259:14 284:11,16
285:5 299:14
303:10 313:9
314:3 320:20
324:9 326:16,20
329:19 335:18
336:16 338:2
352:21 357:11,15
358:2 362:14
369:13,21 370:2,5
388:17 389:1,2,14
meaning 93:5
237:22 334:9
349:3 387:10
meaningful 150:17
153:4,6 192:5
290:1 367:4 368:4
368:9,11
means 79:13
125:13 297:10
302:9 314:1
324:10 360:11
367:6
meant 75:20
132:19 133:1
144:9,10 196:16
measure 3:20 17:5
21:18 23:18,20
24:2,16,17 25:9
25:20 27:6,7,8,11
27:19 30:3,7 33:4
36:1,3 37:9 38:8
38:16,17 40:8
43:22 44:18 45:8
46:22 47:2 49:11
50:2,15 62:16
64:18,22 65:8,10
68:18 69:15,19
70:21 71:19 72:13
73:12 74:16 75:18

76:4 81:22 83:9
83:13,17,17,20
85:1,1,2,15,16,17
86:1,21 87:8,11
87:12 89:5 96:1,5
96:6,21 99:17,21
100:7,10 101:19
102:2,22 103:4,7
103:14 109:16
110:6,7,14 112:14
112:20 116:4,14
116:18,21 117:7
118:8 121:1,13,13
123:2,3,20 125:2
126:22 127:22
128:22 129:3
130:5 131:8 134:8
134:20 136:6,11
136:12 138:18
140:7 141:10,19
142:17,17,21
143:1,4 148:7,13
149:12,16,19
150:8 154:20
155:1,12 156:21
157:3,17 159:10
161:16 162:5,7
167:4 169:4
170:12,14 171:5,6
171:21 172:7,15
173:18 176:5,8,18
177:15,18,19,20
177:21 178:20
179:3,9 181:1,12
182:7 184:18
186:2,8,11,13
187:2,15,15 188:2
188:10,12,16
189:3,17 190:4,16
193:1,4,8 194:5
194:10,12 195:20
195:21 196:1,10
198:22 199:8,9
200:19 201:2
204:6,19,22 206:5
206:10,21 207:13
207:15,18,19

208:2,15 209:1,9
210:9,10,11,22
211:17,18,22
212:15,16 213:16
214:2,3 216:19
217:12 219:7,22
220:4,9 221:4,6,8
224:20 227:8,11
227:12,18,21
228:9 229:22
230:9 231:7
232:14,15 234:3,5
234:14 235:12
236:1,9 237:4
239:14,22 240:7,8
240:10,22 242:1,9
242:10 246:12
247:8 249:13
250:11,13 251:9
255:9 256:3
257:12 258:18
259:3,6,17,22
260:5,6,7,9,10,13
260:16,17 261:6
262:20 263:14,14
266:17 267:14
268:13,13 269:1,3
269:6,18,21 270:3
271:1,15 272:9,17
272:18,21 273:3,3
273:4 275:18
276:18 277:3,4,6
277:15,16 278:21
280:13,17,19
283:16 284:14
285:12,12,14,16
285:18,19 286:5,5
286:10 287:6,22
288:5 289:10,12
289:16,21 291:6
291:13,16 297:6,8
299:22 300:1,7,9
300:21 302:1
303:18 304:6
305:12 307:2
308:7 309:2,16,17
311:11 312:5

313:13,16 315:13
315:17,20 316:6,8
316:9,11,12,15,16
317:7 320:11
322:8,10,11,15,21
323:5,14,20 324:1
324:8,22 325:15
325:16,19 326:7
326:10 327:5,10
327:12,14,18
329:8,18,22 330:7
330:8,10 332:11
332:12,18,20
333:8,22 334:3
335:14,17,19
336:5,9,10,12,16
337:5 338:9,16,19
340:2,6,7,8,16,18
346:6,11,13 347:1
349:11,17 353:11
355:10,11,16,18
357:9,12,14 358:2
358:3,14,16,21,22
361:12,14 364:6,6
364:10 365:1
366:1,8,12,13
370:8 371:11,20
371:21 372:1
374:13 376:7
381:5 382:2 383:5
383:7,7,15 384:12
385:6,8 386:10,17
387:14 389:15,16
390:2 391:12,13
392:4,19 393:2
394:13 400:5
401:20 405:8
406:8,12 407:5,7
407:9 408:5,10,14
measure's 162:14
387:11
measureabilities
121:18
measured 134:9
195:9 272:6 298:6
306:21 310:12,13
measurement 2:7,9

5:6 19:22 28:10
28:21 32:7 47:11
56:17 65:19 86:11
220:9 308:2
355:19 357:3
383:12,13 387:7
measurements
137:19
measures 3:16 9:7
9:12 11:11 13:12
14:19,21 16:12,18
17:9,11,21 18:8
18:12 20:7 21:6,9
21:16 22:18 23:8
24:2,7,11,19 25:2
25:18 26:10,13,19
27:3,15,21 28:3
28:11,14 29:19
30:1 31:10,19
32:15,21 33:6,13
33:15,18,21 34:3
34:6,13,17 35:2,4
35:8,13,18,19,21
36:7,19,19,22
37:3,4,5,7,20 38:1
38:12 39:3 42:3,6
42:19,20 43:3,17
43:18,19 44:10,21
45:3,7 46:1,5
47:19 48:7,9,13
49:15,19 50:2,3,4
50:8,14,22 51:4,7
51:9 52:1 53:6,8
53:11,15,16,19,19
54:1,3,11,20 57:6
59:17 60:5 62:10
62:18,21 63:3,3,8
63:10,19 64:1,9
64:11,14 65:21
66:21,22 69:7,8
69:11,14,20 70:4
70:6,8,11,14,19
72:10 73:5,18,19
74:2,6,21 75:1,11
75:12,12,18 76:1
76:16,22 77:1,5,8
77:17 78:18,19

79:3 80:8,9,11,13
80:14,16,22 81:1
81:2 83:15 84:9
85:13 90:2,9,12
90:18 91:3 93:20
103:15 104:7
110:2,17 119:9
120:5 122:20
126:8 129:5 134:2
142:2,8 145:1,4
154:18 159:14,14
161:21 162:9,20
165:17,20 166:10
168:14,20 169:17
170:3 172:2,9
176:11 177:7,16
178:12 186:5
188:22 189:5,18
190:21 194:12
196:14 200:14
201:1,9,12,22
202:7,10 203:9,22
204:12 206:13
207:9 209:21
210:2,11 212:18
214:7 215:1,21
216:6,13 217:5
219:8,12 227:15
228:4 229:8
230:18 238:5,6,11
252:12 258:22
260:3 265:16,17
271:7 272:10
275:6 278:2,7
279:10,18,20
288:17 289:18
290:17 297:21
300:10,15,17
306:14 321:12
326:21 333:9
337:2 339:3,5,15
342:21 345:16,17
345:22 346:1,3
347:11,20,21
348:3,6 357:22
359:8,9,14 361:11
361:21 363:12,19

364:14 365:15,21
369:6 370:9,20
371:7 374:21
379:2,4,10,22
381:7 382:6,14,18
384:17,18,22
387:2 388:12
389:2,6 390:13,14
390:18 391:3
393:5 401:19
408:19 409:3
measuring 31:20
117:7 131:1 242:5
242:6,17 243:22
244:17 255:3,16
280:14,18 286:17
289:22 321:16
325:14 378:10
389:18
mechanics 110:14
mechanism 109:11
134:17 144:3
228:7 379:18
mechanisms 71:5
71:10 140:17
218:18 227:21
372:15
medicaid 1:13
77:19 90:3 95:2
105:12 108:15
111:7,12 113:6,7
114:3,8,22 115:5
120:11 140:6
141:14 143:10
193:20,22 194:3,5
211:8,14 212:3
215:22 216:9
217:20 233:18
237:18 239:14
240:2 245:4 246:3
252:16 253:4
254:20,22 255:4
255:13 266:17
267:16 282:8
291:15 292:8
307:1 321:1
342:11,22,22

343:3,6
Medicaid/CHIP
249:15
medical 1:16 12:7
13:6 18:6 83:7
93:15 114:18
115:10,13 239:16
280:3 304:17,17
306:4 350:17
351:22 378:7
383:22
medical-dental
230:11
Medicare 1:13
360:19
medicine 2:5 13:4
13:22 16:9 18:5
55:8 239:9 306:2
medium 117:16
meet 69:11 100:7
127:11 155:1
161:16 173:18
204:7 251:13
408:5
meeting 1:3 5:7,9
5:17 6:15 19:8
23:11,15 25:11,14
25:22 26:15 39:6
39:17,20 40:3,11
41:2,3,4 61:6
67:22 68:15
104:21 157:22
166:14 174:9
319:5 345:7
374:14 410:4
meetings 23:13
39:12,14
meets 150:3 157:3
169:2
melanoma 277:1
278:4,6
member 3:19 4:20
19:3 26:17 40:13
40:17 99:16
312:14 318:20
385:14 390:10
409:11

members 6:7 24:13
24:18 25:8,12,17
28:6 51:11 70:19
78:10 90:22 120:5
164:20 165:4,9
234:19 240:21
252:3
membership 23:1
26:20
memory 247:14
Memphis 1:18 11:6
mention 13:15
187:6 303:3
mentioned 28:5
30:14 35:13 37:7
40:8 66:15 68:6
69:18 77:16 80:10
83:6 88:19 113:4
188:21 230:2
260:3 285:19
307:17 311:10
merely 275:17
message 221:12
messaging 173:4
messenger 74:12
met 1:8 52:16
87:19 127:6
209:18 264:16
meta-analysis 97:1
248:4
method 113:5
150:14 191:3
192:2 335:13
338:14
methodologic 21:3
methodology
186:16,18 206:9
308:20
methods 57:3
146:8 147:14
metric 137:4
294:17
metrics 54:5 357:1
379:21
metropolitan
366:12,14,15,17
367:1 382:9 388:2

392:13 399:22
Mexico 17:17
Michael 1:14 351:5
391:16
Michael's 300:13
397:17
Michigan 1:20
15:11
microphone 124:8
179:5 186:17
188:17 202:18
208:10 245:2
259:11 365:8
microphones 5:20
mid-year 40:4
midnight 356:6
360:2,4,6,11,14
midnights 356:3
mike 2:3 5:21 10:5
54:9 71:21 76:1
318:20 319:7
393:3
mikes 104:18
mild 376:10
million 34:4 230:13
230:15 348:13
mind 256:4 288:17
352:16 363:11
371:12 383:10
386:14
mine 10:4 174:4
325:3
Minnich 1:21
10:15,16,21 392:1
395:1 398:10
399:10 402:18
404:11 405:5
minority 100:18
331:6
minute 146:3
192:20 268:14
344:16,18 345:2
minutes 19:19 65:9
154:5 164:5 314:6
344:19 345:2
391:10
misconception

82:16
misinterpret
389:10
misinterpreted
380:19
misnomer 406:6
missed 141:1
191:13 361:9
missing 15:22
103:20 192:7
224:18 239:2
296:11 400:13,19
misspoke 354:10
mistake 391:17
misunderstanding
400:18 401:2
model 175:22
models 215:6
moderate 96:7
108:16 113:2
118:2,7 123:22
125:21 127:7,8
128:5,14 132:8
146:11,18 150:19
151:7 153:9 156:1
156:12 160:8,14
170:21 171:1,8
172:21 182:4,12
182:14,16,20
183:17 184:6,13
185:2,8,15 191:4
191:20 192:9,16
198:11,18 199:19
200:5 208:4
209:16 210:19
219:18 220:22
232:17 233:1
234:1,6,11 235:13
235:18 246:13,18
248:8,11 249:6,10
250:2,7 262:2,9
262:18,22 263:5
264:3,8,21 265:4
266:8,12 267:5,11
268:2,9 295:19
296:5 297:2 303:1
304:1 307:9,14

308:10,17 309:7
309:12 310:4,9,22
311:5,18 312:1
328:1,8,12 330:16
330:21 331:13,18
334:16,21 337:16
337:20 341:20
342:5 343:13,18
376:10 398:2,7,21
399:6 402:8,14
404:4,9,19 405:3
405:16,22
moderate-high
262:18
modifiable 35:4
36:14 37:22 41:12
65:3
modified 406:17
modify 114:18
143:13
molar 96:9 97:4
98:18 176:12
molars 87:1,3
96:13 98:15,16,18
143:5
Moline 1:22 16:6,7
71:21 354:5 406:5
407:10
moment 131:20
157:11 346:3
Monarch 372:16
373:9,10
money 95:15
monitoring 251:6
256:2
Montgomery 379:8
month 334:9
months 7:9 93:12
111:21 112:1
209:15 225:6,10
282:5 284:8,8,9
303:9 321:13
334:8 346:18
366:11 392:7,12
399:12,21
moot 383:1
morning 5:4 7:13

9:2 10:15 12:10
12:20 13:3,18
14:9 15:3,18 16:6
16:14 17:14 18:2
19:12,18 22:11
47:22 71:19 72:8
89:12 109:19
162:14 236:3
270:11 293:4
295:3
Morsell 6:22
mortality 50:12
motion 314:18
motivated 61:4
motivation 133:20
mouth 176:13
179:14
move 27:9 67:9
68:18 76:2,3 89:1
90:17 96:1 100:21
103:12 125:13
128:17 130:20
140:21 150:7
152:20 157:17
161:9,13 162:21
166:19 175:8
176:5 184:16
185:17 192:18
196:4,15 198:20
207:11 209:1
228:6 241:7 243:3
286:14 292:22
298:20 399:9
moved 136:2
275:17
movement 90:9
94:19
moves 90:10
moving 85:22
94:18 123:7 193:2
207:14 259:8
363:9 404:16
MSA 366:14
368:11
multi 49:13
multi-factorial
138:1

multi-source 400:3
multi-stakeholder
25:4
multiple 28:7 33:4
57:12 83:10 192:6
222:16 236:6
248:20,21 337:10
380:18
Multiples 147:18
Munthali 2:10 3:4
3:10 5:3,4 19:15
28:4 30:13 34:16
38:5 39:11,15
41:10 47:15 65:15
67:16 71:17
116:19 124:22
125:5,8,12 147:15
147:19 149:5,8
150:2,6 151:20
152:17 156:18
157:14 162:8
163:21 166:8
169:14 171:13
173:8 178:14
188:13,18 189:15
190:9,18 202:4
237:1 248:13
250:14 278:8
279:19 296:2,8,10
297:5,11 299:1,4
299:7,10,13
302:15 312:16
358:13
mute 6:14

N

N.W 1:9
nadir 92:1
name 5:4 6:9 10:5
10:16 12:10,21
13:19 15:4,18,21
17:3 327:12
345:19
narrow 227:15
240:13,16
narrower 236:15
nation 372:8,10

national 1:1,8 2:1
12:7 17:19 20:21
20:21 30:16 48:17
50:7,18,22 61:14
62:22 79:6 94:11
110:12 123:15
185:4 323:14
348:21 372:5,6
392:16 396:1
natural 64:13
naturally 175:20
nature 234:17
287:17
navigate 112:8,10
NCQA 9:9 14:3
279:18 291:11
294:8
near 85:21
nearly 396:11
necessarily 109:7
219:10 222:5
277:9 278:5 291:2
301:9 317:22
343:1 353:21
369:3 382:11
necessary 114:12
166:4 179:20
282:13 290:14
necessity 114:18
need 21:1 29:22
47:5 60:8,16 67:1
86:20 110:3
112:17 113:9,10
124:18 130:3
142:7 145:12,19
163:16 200:1
205:4 220:21
221:6 239:13
248:14 269:10
290:17 294:13,16
314:22 342:1
365:14 369:7
370:22 371:8,18
372:10,18,19,21
372:22 373:1,3,4
374:14 386:13,14
387:3 390:20

393:6
needed 53:16 57:9
59:18 86:4,5
112:12 197:17
213:20 214:18
215:4 265:22
322:16
needing 313:2
needle 209:2
needs 52:6,11 59:1
59:4,10 66:10,19
104:22 141:21
221:19 229:7
235:1 251:9
257:12 283:21
291:17,20 363:17
negative 160:6
199:18 278:18
298:17 342:19
neglect 226:1
negotiation 240:14
neighborhood
376:3
neighboring
403:11
neither 352:10
nerves 120:2
nervous 342:8
networks 80:1
never 141:6,9,13
141:15,15 178:2
195:7,13 385:16
385:22
new 8:21 10:12
17:17 18:4,10
76:18 80:15 83:2
86:7 90:18 112:22
113:14 122:4,18
131:12 155:8
158:18 159:10,14
160:3,4 164:4,11
170:17 181:6
199:8,14,16 203:2
238:2 282:19
287:10 303:17
318:20 367:7
380:22 394:5

405:7
newly 37:2
newness 134:1
news 20:13
nice 284:6 317:7
    318:2 408:16
night's 408:17
NIH 12:8 375:18
nine 33:15 160:14
    200:4 262:8,9
Nishimi 2:14 7:2
    125:22 172:18
nitpick 332:5
nitpicking 332:1
nitty-gritty 384:22
nobody's 370:17
noise 47:11 244:6
    251:13
nomenclature
    189:8
nominated 8:14
nominations 26:8
non 81:7
non-clinical 14:20
non-compliance
    355:7
non-dentist 81:4
non-endorsed 63:3
non-population
    189:17
nonprofit 52:8
noon 68:1
normal 341:11
normally 362:8
North 1:22
Northeastern 1:14
    14:11
not-for-profit
    378:18
notation 102:21
    236:20 332:10
note 95:7 157:4
    159:9,15 161:17
    204:7 218:4
    257:17 299:16,20
    313:18
noted 64:8 100:19

153:20 157:15
188:9 260:19
300:4 331:8,8
395:5 404:12
notes 184:17
    255:22
noticed 15:20
noticing 326:12
notify 163:15
noting 303:21
    401:5
notion 77:12
    216:14 362:14
novice 206:6
NQF 2:6 3:11,19
    4:20 5:6 6:11
    11:11,15 13:16
    18:15 19:9,10
    22:16,19 23:1,12
    27:6 28:12,15,20
    29:4 30:15 31:8
    32:6 33:18 34:11
    42:8 43:1 44:20
    48:2 49:18 63:2
    71:4 75:2,4,6
    83:15 129:2
    161:16 165:7
    189:3 200:20
    201:6 204:7
    260:10 276:21
    277:1,2,5,20
    278:7 279:17,21
    357:22 359:13
    374:14 381:6
    390:10 408:5
    409:17
NQF's 7:21 278:2
NQS 32:17 33:10
nuances 159:13
    189:7
number 9:18 10:22
    12:16 32:20 33:16
    35:2,10 59:14,19
    60:3 64:11 70:5
    75:2 101:12
    116:14 137:22
    143:18 148:3

158:17 173:12
181:11 186:20
195:4 205:9
207:15 280:1
289:17 297:17
298:4 313:5
352:22 356:22
363:16 367:4,15
378:3 382:5
383:16 391:6
numbers 119:19
    123:18 136:10
    139:1 159:4 183:4
    185:6 245:15
    255:3 333:17
numerator 98:13
    101:2 102:16,20
    106:17 107:22
    117:6 186:13
    264:11 332:2,13
    392:6 399:11
nurse 46:7 81:15
nutrition 53:9
NYP 1:16

O

o'clock 390:21
O-F 3:1 4:1
Ob 360:16 399:15
observation 236:16
    356:1,10,14
    359:22 360:11
    403:5
observe 257:5
observing 236:21
obstetric 346:21
obtained 333:22
    334:4
obviously 126:4
    133:5 140:7 214:5
    227:9 240:16
    360:6,14 390:12
occasioning 352:4
occupational 16:8
occur 134:4 212:13
    289:8
occurred 275:16,16

occurrence 403:12
occurring 92:17
occurs 65:5 281:15
October 80:17
odd 289:11
offer 24:18 100:3
office 210:5 211:19
    274:17 277:11
    293:11 353:15
    354:12,17,20
    376:12 381:11
Officer 12:7 15:5
    16:2 46:4
offices 239:10
    290:5
officially 303:4
Officials 2:2 15:6
offline 315:10
oh 11:1,18 62:1
    127:21 139:15
    140:21 149:5
    153:14 164:1
    173:21,22 179:6
    180:14 181:16
    182:8 183:21
    200:21 225:7
    231:21 247:17
    256:6 257:18
    262:7 268:15
    272:13 293:15
    299:2 356:16
    391:17,19,22
    400:6 406:15
okay 10:1 11:1
    16:22 17:1 18:18
    19:14 21:17,19
    39:15 47:15 65:7
    71:18 72:5,15,22
    76:1,3,4 95:5,21
    98:4,5,7 99:14
    100:12 105:20
    110:5 121:20
    123:5,9,10 124:6
    124:9,21 125:5,10
    125:10 126:12,19
    127:1,18,22
    128:13,13,13,16

129:13 130:11
134:6 140:20
141:7 142:18
144:16 145:14
146:5,15,17
147:15,19 150:6
150:11 151:2,3,4
151:6 152:19
153:2,3 154:3,6
155:15,17 156:5,7
156:9,11 157:14
157:16 159:20,21
160:12 161:11,15
162:3,12 163:22
164:12,16 165:6
173:20 176:3
179:2,6,22 180:7
180:10,15 181:10
181:16,22 182:1,9
182:9 183:7,9,12
183:15 184:1
185:17 188:20
189:15 190:10,22
191:8,15,18,22
193:2,16,18
195:11,13 196:4
196:18 198:20
200:7 202:2
203:19 204:3
205:2,13 210:3,17
227:4 231:20
232:8,10,21 234:3
235:9 237:16
239:20 241:10
242:13 243:10
245:3 246:8,22
248:17 249:4,21
250:4,10 258:16
259:7 260:12
261:20 262:7,20
263:22 264:5,19
266:5 267:8
268:11 269:6,11
272:1,22 275:4
276:14 283:3
285:9,21 286:8
288:14,20 293:2

296:14,16,17,19
297:1 298:10
299:12 302:3
303:14 304:1
307:5 308:7 309:4
309:14 310:1,6,11
310:20 311:20,21
319:3,14,22 320:4
327:22 328:4,22
330:1,11,12,13
331:1,11 332:17
334:13 335:5,7
337:12 339:15
340:21 341:21
342:3 343:20
344:7,13 346:10
349:16 351:7
356:16 357:4
383:9 386:2 388:3
390:8 394:12,17
394:21 395:11,16
397:21 398:9,18
399:8 400:5,17
402:5,16 403:19
404:1,22 406:2
408:2
old 4:4,7 93:8
95:12 96:2,7
153:21 162:11
204:20 225:4,18
226:17 395:14
older 197:21
217:19 223:2
olds 98:12
omitted 253:1
once 20:16 27:21
38:8 59:9 94:20
124:14 187:5
206:18 207:3
216:18 217:16
290:11 304:10
337:3,3 382:21
one's 308:19
one-to-one 277:8
ones 37:21 183:4
255:5 291:21
387:10 407:4

ongoing 48:3
137:11 271:13
287:1 291:5
online 122:19
onwards 121:3
Oops 76:12 158:10
open 5:17 155:10
180:4 183:10
205:4,5 264:4
265:1 266:9 267:7
268:4,19 295:21
296:15 307:11
308:12 309:9
310:5 311:2,19
327:14,19 328:3
330:18 331:15
334:18 337:17
341:21 343:15
390:12 391:2
394:16 398:4
399:1 402:10
404:5,21 405:18
operation 341:11
operationalization
117:5
operationalized
117:7,10
OPERATOR 72:3
205:7 391:4
opinion 25:7 176:1
182:17 280:10
298:5 300:2 302:7
opinions 169:22,22
opportunities 6:3,6
53:3 368:15 395:2
395:3
opportunity 44:7
64:20 69:2,20
73:21 76:14 100:2
166:18 167:16,21
174:3 178:3 181:5
233:6 262:13
275:13 306:17,19
306:22 307:6
opposed 134:11
254:13 307:20
optimal 128:3

184:4 188:6 329:6
option 156:16
180:4 203:21
312:13 314:14
optional 129:11
131:16 132:6,14
132:19,21 133:12
options 145:18
227:14
oral 4:14 16:4 37:2
37:7 76:8 77:13
77:22 80:8 81:1,2
81:21 82:5,12
83:5,12 84:7 89:2
96:16 108:2
111:12,16 142:13
143:16 177:20,21
196:13 210:12
212:15 213:15
233:12,13 239:18
262:15 265:10
269:18 270:1,16
271:19 272:2
273:10,11,22
274:1,21 280:15
280:16,22 281:6
283:22 287:13
289:5,7 290:19
293:8 315:16
316:18,22 317:3
317:17,18 338:10
338:11,13,17
341:4 354:1,19
376:9,16 377:19
378:2 385:12
402:22
Orange 388:6
order 126:16
136:20 142:10
165:14,21 166:16
168:21 201:1
302:7
organization 10:8
58:13,18 76:18
354:6 378:15
organizational
58:20

organizations 14:5
51:21 58:19 78:13
78:13 339:18
organized 176:1
orientation 348:5
orientations 67:10
original 145:4
originated 49:12
osteoporosis 35:22
other's 20:12
ought 378:15
outbreaks 406:13
outcome 62:12
75:11,22 96:11
126:8,10 127:4
182:2,2 232:16
248:5 262:1 273:4
273:5,9,12,19
274:4,12,14,18,22
275:7,11 277:12
277:16 278:12,13
278:17 287:22
292:19,21 297:21
316:21 317:16
323:12 375:2
392:19 393:5
outcomes 12:1 17:7
34:8 75:18 76:5
87:6 247:22 298:1
outline 168:6
outlined 114:12
outpatient 50:21
347:15 348:1
355:3,15 398:16
outreach 33:14
outside 16:18 36:17
366:20
outweigh 160:6
199:17 231:5
outweighs 298:7
overall 27:18 83:9
96:16,17 105:6
128:2 161:14
178:8 184:3 188:5
192:21 200:8,11
204:5,18 223:7,10
223:20 250:15

251:17 258:19
268:17,22 304:8
312:5,10 313:8
317:3 328:21
344:3 396:6,14
406:3 408:4
overarching 79:19
overlap 80:3 82:6
316:7 360:15
overlook 284:19
overnight 390:17
overplay 323:7
override 175:3
oversee 13:22
14:11
overseeing 19:21
23:7
overstating 256:9
overview 3:7 27:5
68:17 73:18 76:16
208:15 259:16
346:2 347:3
overwhelming
207:1
overwhelmingly
379:22
Owens 2:14 72:1
345:18,19,20
347:2 355:1 356:9
356:17 357:11,14
359:1 372:4
375:16 382:15
388:10 397:17
400:17 401:14
403:14,20 407:15

_____
P
P-R-O-C-E-E-D-...
5:1
p.m 68:1 205:18,19
269:15,16 345:9
345:10 410:6
package 293:21
page 3:2 4:2 147:10
148:18,18 149:11
183:2 184:21
207:17 242:19

269:17 297:13,13
297:13,15 346:13
391:13
pages 207:20
paid 8:6 136:20
211:10,13 214:20
224:7
pain 292:18
painful 292:6
pair 200:16 203:15
203:18
paired 200:19,22
202:6 203:11,20
203:21 204:3
Pam 345:18,19
358:15
Pamela 2:14 72:1
panel 13:16 18:15
87:16 291:11
350:8 351:3
panels 17:12 88:12
paper 9:15 31:13
31:17 319:11,16
parallel 80:14
199:8 212:15
265:16 295:13
parameters 65:16
179:11 309:1
374:15,17
parentheses 35:11
parents 217:17,17
217:20
parlance 81:9
parse 288:22
parsimony 28:19
289:16
part 11:10 12:8
15:12,21 17:11,22
18:21 30:1,17
32:12 33:11 48:18
59:13 66:6 70:12
71:6 86:9 92:15
94:2 104:7 108:1
108:13 117:20
118:8 122:13,16
130:17 158:1
159:10,18 173:14

178:5,6 189:2
227:22 230:8,9
243:5 247:9
253:19 270:21
276:18 278:21
289:13 304:16
314:10 321:9
336:1 339:6 347:7
349:5 359:11
364:20 367:1
371:3 374:10
379:13
partially 367:10
PARTICIPANT
12:17 34:14 73:8
76:2 180:12 190:8
202:17 298:19
315:19 321:6
328:15 385:19
participate 18:9
67:19 69:2 343:6
participating 164:7
particular 36:8
40:6 42:18 43:11
59:5 62:21 120:9
164:8 165:1
210:22 216:12
262:16 266:16
286:9 287:18
327:4 330:10
336:15 356:9
357:17 369:19
371:19 372:19
379:10
particularly 30:15
44:7 48:18 55:15
55:19 59:14 60:14
79:12 90:11
249:17 290:5
372:21 375:8
400:20
partly 357:21
partner 30:6
partnership 49:11
62:16 348:9
Partnerships 47:17
parts 33:10 110:11

party 365:12
pass 27:8,12 100:6
100:8 116:22
162:7 250:11,12
339:19
passed 150:8
195:22 210:15
287:7
passes 27:9 259:6
269:3 339:15,16
passing 9:15
password 6:10
path 75:22 126:9
292:19,21 307:20
308:1,1
pathway 293:11
322:17,20,22
patient 54:18 97:8
112:7 132:17
140:4 142:3,4,5,5
142:6,8 181:9
275:13 276:4,16
281:20,22,22
282:9,19 283:1
292:17 293:10
298:13 326:5
327:16 351:13,19
352:1,5,9 354:10
355:5,7 403:17,18
patient's 367:21
patient-level
148:11,16 333:3,4
400:14
patients 110:8
160:7 211:8,14
214:11 342:19
378:3 380:8
patients/populati...
199:18
Patricia 1:20 15:9
Patrick 2:15 72:2
346:4,7 349:10,13
359:2,5 375:16
393:10
pattern 179:15
251:10
Patty 173:21

pause 127:14,17,20
128:7,10 146:14
150:22 155:14
156:4 160:11
162:2 183:6,11,14
184:9 185:11
191:7,10,12,16
192:12,20 198:14
199:22 200:9
204:14
pay 139:21,22
255:11,17 294:16
319:19 364:16,16
389:11
payer 364:18
382:17
payers 140:9 343:3
paying 71:9
payment 49:16
payors 263:18
PC 209:3
PCP 402:22
PDI 3:18 372:17
409:6
pediatric 13:21
74:22 77:21 93:8
122:14 198:1
239:9 285:1 290:5
317:8 347:8
348:14 375:22
377:21 379:2,4
384:16
pediatrician 8:20
10:11 12:11,21
91:11 92:10
212:10 213:15
294:7 346:5
353:16 362:12
pediatrician's
211:19
pediatricians 81:14
211:6,9,13 213:9
224:7 225:17
230:2 304:22
377:4
pediatrics 8:22
215:14 239:4

356:4
Pennsylvania 10:7
10:8
people 42:9,15
55:20 81:5 111:13
124:12 126:3
139:5 142:15
145:12 147:6
171:5,11 172:12
173:12 174:11
197:15 206:10
227:16 236:20
247:2 252:6 254:6
260:15 267:18
269:9 279:8 283:7
291:19 301:6
358:8 373:10
378:14 385:1
percent 43:20 79:7
82:4,5,7 115:4
129:21 136:21
139:22 140:2
145:9 212:5 225:9
231:4 239:19
241:16 243:14,15
243:17,18 248:16
298:22 299:6
312:9 328:14
343:22,22 344:1
percentage 100:14
143:19 208:2
256:18 269:21
315:13 331:3
percentages 256:14
perception 257:11
perfect 69:11 71:17
121:12 362:4
performance 2:7,8
5:5 19:21 59:17
61:16 85:18 98:8
98:9 99:10 121:11
126:18 128:1,3
133:19 137:3,5
139:12 144:6,12
158:3,4 173:7
181:1 184:2,4
188:6 195:20

196:3,8 208:22
209:3,5 231:10
234:5,10 241:14
247:8 252:20
254:12 261:2
262:22 263:4
297:21 298:11
307:6,9,13 316:10
329:1,3,6,13
330:13,16,20
359:10,13,16
361:15 362:9,15
363:2 364:11,17
376:7 386:11
394:21 395:7,11
397:22 398:2,6
performed 86:6
118:1,2,3 133:7
period 23:3 38:9
68:6 225:20 254:8
282:6,10,16
285:20 316:10
325:11 326:13
338:11
period's 314:16
periodic 92:14
270:1 281:2,12
282:2 305:5,15
315:16 316:17
322:16 323:11
periodical 280:16
periodicity 212:11
287:17 290:20
294:20 295:11
periods 112:16
333:21
permanent 87:1,2
96:9,13 97:6
98:15 221:17
222:20 223:9,22
Permanente 1:17
12:12
permissible 312:12
person 39:12 70:15
82:21 89:18 118:7
147:14
personally 70:1

157:11 244:21
252:7 387:17
perspective 157:1
165:11,17 172:17
174:6 218:3
300:13 350:5
352:16 362:5
371:10 386:18
perspectives 25:5
152:5
persuade 306:7
persuasive 94:7
pertained 338:22
pertinent 352:8
phase 32:11 33:9
290:15
phenomenon
122:18 223:17
phone 6:15 39:13
72:2 126:3 224:3
346:4
phones 6:13
phrase 108:19
physical 33:21
53:10 277:3 280:2
physician 12:12
13:5 17:4 51:18
230:14,16 277:2
279:6,12 284:17
374:6 381:22
physician's 376:12
physicians 17:8
81:15 129:10
277:11 305:12
372:3 377:3,4
378:8 397:13
physics 138:6
pick 9:17 119:4
141:12 154:15
325:16
picked 12:15 84:14
112:16 220:13,16
284:9 295:7
pickup 194:13
picture 141:21
142:1 276:19
378:16

piece 31:17 106:22
114:11 115:8
116:1 136:3
142:12 144:8
178:6 222:10,21
245:16 253:8
382:7
pieces 142:20
pillars 20:20
pits 97:5
place 24:4 29:4
44:9 60:17 94:1
117:14 118:12
121:14 209:1
357:19 364:8
368:10 385:20
placed 97:5 101:5
181:7
placement 96:12
97:4 98:10 180:19
308:3,5
places 94:8 175:3
337:10
plan 60:1,17 75:20
79:20 110:6,18
111:17 113:17
120:10 131:2
133:3 137:13
139:21 144:12
155:6 160:3
199:15 220:6
249:16 264:15
266:18 271:16,20
274:3 275:18,19
276:13,15 282:1
287:14 290:10
292:4 307:3
311:12 320:10
321:1,16 325:16
326:7
plan's 333:13,14
planning 58:20
plans 78:5 79:6,10
120:8,8 129:20
130:2 131:3
132:21 135:21
139:22 140:9

143:15 144:2,4
154:22 187:14
201:12 220:14
245:20,21 248:22
254:2 256:13,14
282:8 286:20
290:21 324:19
plate 29:18
play 130:7 138:4
282:17 316:22
Playbook 57:21
please 5:19 19:2,5
24:13 30:5,11
54:10 56:13 92:7
101:8 123:21
128:12 205:6,9
232:12 235:10
241:11 242:7
243:12 246:9
258:18 261:21
264:1,19 266:6
267:22 269:13
275:22,22 295:17
306:18 307:7
308:8 309:5 310:2
310:20 311:16
315:18 327:21
330:14 334:14
337:14 341:18
343:11 347:1
385:3 391:5,22
395:12 397:22
398:18 402:6,17
404:2 405:14
408:2
pleased 85:12
plenty 378:11
plus 93:6 115:21
178:11 305:13
PMs 192:8
pocket 140:3
point 40:20 41:11
42:5 45:19 46:3
55:14 66:5 74:19
84:3 104:1 107:6
109:2 120:17
122:7 135:14

136:1 137:7 139:2
139:17 148:13
152:18 158:20
169:10 176:16
178:15 187:5
194:7,11 197:15
207:14 212:4,20
224:6 228:18
238:13 240:9
242:8 252:11
253:17 257:4
260:15 285:2
286:22 297:11
315:7 322:4
333:18 339:8
369:13 378:13
380:21 383:1
394:2 397:17
401:14
pointed 194:6
201:18 212:14
225:7 239:17
403:8
pointing 123:12
points 70:21 99:19
116:22 143:20
179:21 359:7
policy 2:4 13:6
42:20 43:2 89:21
120:15 245:19
254:12
pollution 33:22
poor 100:18 227:2
331:6 380:7
400:13 401:9
populate 402:1
population 3:11,13
3:14 11:16 15:14
16:7,17 17:21
18:4 21:7,12 22:3
29:3,7 31:10,18
31:21 32:8 33:13
34:6,9 41:14 42:1
42:19 43:13 44:3
44:11 47:19 48:1
48:7,10,15 50:13
51:7 52:2 54:22

55:22 58:9 62:9
62:19 63:1 64:14
65:1 66:3 67:9
74:22 94:14,20
95:4 108:14
109:20 111:3
115:3,20 128:4
134:9 138:15
140:12 142:11
181:9 184:5
187:22 188:15,22
189:5,11 190:3,15
198:2 222:3,11,14
223:4 228:14
238:12 239:19
254:20 256:12
264:14 283:17
285:1 320:8,21
321:19 325:9,22
326:15 346:17
347:14 348:4
358:5 360:20,20
363:10 366:10
370:16,20 371:2,4
371:8 374:3
378:17 392:12,16
392:16 399:21
population's 253:5
population-based
14:18,21 34:3
65:10
populations 30:18
33:4 42:22 48:15
50:6 100:17,18,19
119:15 136:9
138:10 160:7
186:22 188:3,7
190:1 222:16
235:2 251:4
266:22 283:16
331:6,7
portfolio 3:8 23:7
28:2,3,12,14,16
28:20 29:15 34:11
34:12 35:11 37:11
178:16
portion 76:9 120:2

171:3 213:4
position 252:17
positive 61:2 93:2
275:17 278:17
298:17 299:11
possible 86:11
102:1 112:10
251:5 301:16
380:17
possibly 245:15
post-vote 175:14
posted 40:13 168:3
potential 103:16
141:11 158:2
256:8 272:20
298:7 304:21
333:10
potentially 141:10
178:12 215:5
217:15 231:9,11
301:1 307:2
347:21 381:15,17
388:4
poverty 53:12
358:4 362:16
394:9
PQI 367:8 372:17
376:4 377:1,5,11
378:6 384:18
390:18
PQIs 366:10
368:14 370:2
372:5 373:17,18
375:22
PQRS 63:11
practical 41:22
57:20
practice 14:1,13
81:17,19 83:1
96:18 97:2 107:14
109:14 139:11
201:10 282:9
317:5 377:18,21
practices 33:8
34:21 59:13 67:3
practitioner 83:18
practitioners 81:10

81:15
precedence 228:10
preceding 32:17
precipitous 394:2
precise 146:6
147:22 191:1
precisely 324:14
predictor 118:22
prefer 99:3 157:10
169:9
pregnancy 399:15
preparation 166:13
prepare 75:4
prepared 25:17
Presbyterian 18:4
preschool 217:1
prescribed 355:9
prescriptive 175:19
present 1:11 2:11
2:18 23:19 85:10
177:1
presentation 23:10
103:3 104:8,8
233:7
presented 69:8
87:16 96:20 210:1
233:10,15 247:12
249:17 260:21
262:14 263:9
317:6
presenters 233:9
presenting 164:21
165:2,16 171:4
376:11
president 2:7 8:22
13:20 16:15 18:3
presiding 1:10
press 123:21,22
124:1,18 128:12
146:10,11,11,12
205:9 391:5 408:7
408:15
pressed 114:6
pressure 34:3
presumably 98:15
108:8 194:22
273:19 284:22

pretty 43:4 206:14
206:17,19 207:4
263:11 274:11
360:12 375:5
381:6 382:22
395:14,14 408:19
prevalence 180:17
prevalent 231:13
prevent 92:4 119:2
276:7 386:5
preventable 357:18
preventative 13:4
31:2 32:14 83:22
140:1 291:1 301:2
prevented 142:5
preventing 91:9
347:17
prevention 4:3,6,9
17:19 20:22 35:3
35:14 36:14 37:8
50:11 53:7 83:20
96:1 112:13
142:19 162:10
197:17 204:19
207:15 259:4
284:21 285:1
287:4,8 288:22
289:8 294:22
317:2 347:6,9
349:18
prevention-orien...
56:8
preventive 208:16
224:11 234:17
235:1 290:10
previous 62:8
100:16 139:14
170:9 176:11
195:3 199:9
200:16 209:20
229:22 272:18,21
273:7,15 285:12
285:14,18 286:4
288:5 289:10
300:1 309:15
315:20 316:7
322:11,15 332:12

344:6
previously 14:17
37:1 104:4 105:18
132:7 181:8
198:22 273:16
287:7 331:5
pride 136:19
primarily 77:19
83:6
primary 8:20 35:3
35:13 36:13 37:8
83:7,19,20 108:21
210:6 214:3
221:16 222:19
223:9,22 245:10
325:14 362:11
375:6 376:10
377:1,3,4,10
378:8 397:13
Princeton 10:12
principal 352:3
400:21
principally 352:4
principle 346:14,15
349:2,21 350:1
351:10,14,18
392:7,9 399:14
principles 56:18
print 160:19
prior 22:4 73:3
134:10,17 135:18
157:18,21 176:5
priorities 25:6
prioritize 372:10
prioritized 59:8
priority 51:1 58:21
100:13 123:16
184:17,22 185:4,5
185:14 215:2
234:14 235:7,9,12
263:8,9,22 264:3
307:17,18 308:7
308:10,16 331:2
331:11,13,17
398:9,11,12,21
399:5
private 63:16 66:8

77:7 348:9
prize 67:7
probably 7:9 21:16
38:19 40:4 65:18
66:6 82:10 93:6
121:7 134:1 139:7
153:22 162:19
218:13 229:9
231:13 232:4
274:7 288:17
301:4 330:6 332:1
360:5 365:13
371:13 384:12
390:16 394:1,4,10
407:2
problem 120:22
145:11 203:14
209:5,5 226:20,22
241:8 285:11,22
305:8,9 307:21
355:2,14 356:1
385:20
problematic 88:8
problems 295:10
380:12
procedure 86:10
112:22 117:11
270:17 328:18
333:12
procedures 120:13
211:9 271:8 287:3
proceed 98:6
248:16
process 3:8 5:13
23:15 26:7 34:7
37:12 38:15 41:8
42:10,16 58:21
59:2 64:16 68:22
69:18 71:6 75:12
76:11 86:9 88:19
90:1,19,22 96:6
96:10 99:6 126:21
127:3 130:4,19
134:22 145:1,10
145:16 157:6
162:17 163:2,19
164:6 166:1

168:12 169:13
170:10 173:9
176:4 178:21
182:10 186:1
195:17 203:3
206:7 207:3
221:18 232:16
262:1 275:5 276:2
277:3,4,16 278:13
278:16 281:9
286:15 291:7
298:1 303:17,18
313:4,13 316:16
316:20 317:15
326:9 329:8 334:6
335:13 336:1,6
338:7,9 339:1,8
339:13 344:6
349:5 350:7,8
379:17 380:22
processed 182:7
processes 57:3 64:7
74:5,14 126:11
290:5 336:4
341:13 400:12
product 62:13
products 13:10
profession 282:3
professional 7:11
8:5 247:10 318:10
professor 14:10
17:16 18:5
program 14:3
63:18 77:19 90:4
90:4 109:4 110:18
111:17,18,20
112:5 115:1
129:20 130:5
131:2,14 132:2
135:21 137:12,14
138:21 141:14,15
143:10 144:12,15
216:7 220:2,3
239:14 241:15,17
243:13,16 244:20
245:1 246:3,3
251:20 252:8,16

253:4,6,7,21
259:18,21 261:2
264:15 265:13
321:17 325:16
326:4,7
program-level
216:6
programmatic
3:11 75:20 215:5
311:12
programs 16:11
45:6 49:16,20
50:5 51:10,17
63:11,17 77:6,7
77:18 79:12
105:12 108:10,10
112:3 115:21
130:8 140:10
143:22 201:11
212:7 214:6
215:22 216:9,18
221:5 228:12
233:19,22 236:6
239:22 244:2,9,11
248:21 249:15
266:18 267:15
290:22 311:9
342:11 373:20
401:17,17
progress 59:7 60:4
158:12,22 159:11
160:4 199:15
251:1,6 347:19
project 2:8 3:7 6:19
6:20,22 7:1,2,3
9:6,8 22:3,5,17
31:9,10 32:10
36:2,4,17 37:12
38:21 39:21 40:1
40:6 41:14,15,18
41:19 48:5,8,12
55:16 56:10,15
57:11,14 60:20
66:2 188:22 348:8
projects 17:21
18:11 29:6,10
38:22 48:2,16,20

48:22 49:2,7
60:15 171:20
278:11
prolonged 290:22
promise 135:7
promote 34:21
216:13 227:16
230:10,19
promotes 224:14
promoting 317:2
properly 363:13
properties 27:11
38:17 186:14
246:12
proportion 95:3
211:14 320:21
321:19 326:14
proposals 165:5
proposed 327:5
329:18 338:14
PROs 192:8
prospect 29:22
protocol 333:6
provide 26:10
29:14 49:14 73:17
79:20 81:13 91:5
108:10 109:6
144:3 145:18
227:17 252:4
275:19 302:16
315:8 346:1
380:22 385:12
provided 24:3 79:8
79:8 80:18 81:11
83:7 101:1 102:15
109:1 216:21
224:19 291:2
302:22 303:2
305:19 307:3
317:14 318:2,5
329:19 331:5
361:12
provider 46:16
78:12 93:18
102:18 106:22
113:15 129:6,19
130:2,6 132:4

133:3,4,5 136:3
140:13,18 201:21
209:6 214:19
265:11 326:6
332:8 362:10,11
363:4
providers 36:21
82:22 83:8 128:3
135:10 138:8
184:4 223:15
298:10 324:12
342:20 343:5
365:3 395:8
provides 294:22
332:7
providing 7:1
214:20 215:7
305:18
provision 31:1
proximal 278:13
proxy 134:20 287:1
public 1:15 3:19
4:20 5:17 6:7
11:7 12:11 16:15
18:6 26:17 31:14
31:16 32:3 40:13
44:22 45:2 49:15
52:18 61:1,12,14
61:17 63:6 68:6
77:6,18 79:12
95:8 108:9 115:21
153:5 157:4 160:2
199:13 205:4,5,11
304:7,9 311:11
312:14 318:21
333:20 372:15
390:10 391:2,5,7
409:11
publish 388:15
published 389:7
publishing 388:16
pull 168:5 188:14
224:3 339:10
pulling 305:15
pulp 118:16 120:1
purchasing 51:18
63:12

purely 392:19
400:1 404:13
406:9
purpose 44:20
49:13 132:16
379:12
purposefully
317:21
purposes 220:2
347:16
purview 172:3
179:1
push 38:21 124:14
131:8 145:20
196:10 270:21
pushed 52:17
302:22
put 6:13 7:15 24:13
29:17 39:2 41:21
42:2 53:21 54:9
60:22 63:5 68:8
74:17,20 76:20
78:17 104:10
106:13 119:10
151:18 166:9
172:11 186:19
232:11 242:3
248:6 256:8,10,22
286:22 292:20
305:19,20,20
333:6 351:10
352:19,20 354:17
359:16 374:17
375:12 397:19
puts 290:14
putting 114:9
209:1 213:13
271:11 292:18
402:3
puzzle 142:13
puzzles 141:22

Q

QQC 182:13,20
qualified 12:2
98:17 129:6
qualify 102:21

332:9
qualities 386:8
quality 1:1,8 2:12
2:13,13,14 4:5,8
4:11,13,15,18
11:9 12:1 13:1,8,8
20:21 30:17 48:17
49:15 50:7,18
51:1,18 61:15
62:22 72:12 73:6
74:12 87:18
101:18,22 105:16
127:5,7 130:18
153:7 182:3,11
208:12 244:2
247:9 252:22
261:1 263:14,15
277:6 278:7 294:2
294:4 305:1 308:2
317:4 318:4,8,16
323:15 334:4
342:15 345:21
347:6,8,9,21
349:19 357:3,8,9
357:15 358:2,11
359:11,17 361:12
368:6,16 372:6
375:3 379:22
380:7 385:8
386:13,21 390:2
400:13 401:7,13
quandary 370:12
quantity 87:18
127:5,7 182:3,10
quarter 72:17
question 21:6
24:15 38:6 43:6
44:15 45:17 55:4
61:12 64:4 99:7
99:16 106:4
107:20,21 114:2
121:16,21,22
128:22 129:2
135:7 138:13
141:8 146:21
153:13,15 158:14
160:17 165:12

170:6 179:18
194:18 202:16,20
214:15 219:16,21
225:14 226:3
234:21 235:4
243:9 247:1
252:21 256:2
264:12 274:5
277:10 278:9
290:4 293:18
298:18 305:1,16
323:10,17 324:16
324:18 329:14
340:5,10,15 351:7
353:9 357:21
361:6 365:13
367:3 375:10,21
382:5 383:21
387:1 388:10
393:9,12
questions 19:14
21:3 24:9 37:11
54:6,9 56:22
68:11 69:21 70:22
89:13 90:14,21
100:3 106:1
110:21 116:7,16
123:2,2,8,14
128:18,21 129:18
140:21 145:15
148:21 150:7
152:20,22 155:10
157:19 158:8,8
164:6 167:21
168:15 169:15
173:9 176:4 177:2
181:13 187:17
193:17 198:3
200:10 210:20
227:5 229:15
231:21 260:8
265:9,19,21
266:19 279:3
293:14 346:9
393:2
quibbling 114:21
quick 28:2 29:17

66:17 73:18
153:13 208:12,15
224:3 225:2 247:7
259:16 303:16
359:6 409:5
quickly 58:11
103:12 168:21
222:8 339:11
409:16
quiet 157:10
quirks 162:16
quite 25:11 35:12
102:13 103:1
105:14 108:3
114:10 149:17
168:8 200:18
245:18 292:15
332:12 342:13
354:16 397:3
quote 88:5
quoted 318:5

R

race 98:21 233:16
256:17 329:9
382:16
races 94:15
radical 223:20
radiograph 271:9
raise 256:8
raised 235:4
240:19 252:12
260:15 265:8,9
266:19 309:15
raises 382:4 388:19
rally 371:1,6
ran 88:18
RAND/UCLA
335:13
randomized 97:16
294:1 301:18
303:13 392:22
range 97:17 215:17
218:5,12 220:10
220:13 221:10
225:16 234:15
236:12,15 237:6

237:21 238:7,15
303:19 380:9
ranges 224:10
rank 168:21
ranked 240:21
rate 3:17 71:20
110:4 147:11
148:13 171:21
217:2 286:9
298:14 301:21
346:12 367:8
372:2 392:5 394:3
396:6 405:10
407:18 408:11
rated 97:14 99:1,1
219:18 262:18
318:15
rates 100:17
130:20 331:5
355:12 372:17,18
376:4 377:1,5,12
382:16 386:6
387:20 396:15,22
397:9
rating 97:16 105:6
190:6 302:22
333:3
ratings 148:15
ratio 396:3,8
rationale 80:7 88:7
149:3 159:12,17
160:5 172:5
176:13 182:3
199:16 215:12
216:12
rationale/causal
126:9
RCTs 87:17 88:2
318:14
re-analysis 360:22
re-submission
301:16
re-use 387:7
re-vote 163:18
342:2
reach 78:17 248:14
256:15,15 258:10

303:12
reached 258:11
296:3 343:22
reaching 257:22
reactive 292:5
read 123:14 137:21
141:2 145:17
274:7 296:5 300:7
302:2 338:18
340:11 408:3
readily 306:22
reading 37:17
326:20 329:15,16
330:2 335:12
387:17 400:15
406:6
readjusted 154:13
ready 72:17 183:8
205:22 241:10
246:9 250:10
258:17 268:12
293:15 390:17
391:11 408:17
real 29:20 58:11
153:13 180:22
214:15 389:11
realistic 112:20
reality 69:13 92:11
289:2
realize 169:19
288:4
really 20:18 21:10
30:16 32:6 33:17
40:22 41:21 44:6
44:8 47:5 58:11
58:16 59:3 61:4
64:17 69:4 73:16
73:16 77:1,17
86:3 87:16 88:20
89:1 93:1 107:5
113:8 122:19
130:13,17,22,22
135:22 139:18,18
141:18 142:16
156:22 157:22
159:11 166:6,14
167:16 172:3,10

172:12,12,18,22
173:3,16 175:17
176:10 177:10
178:2,5,5 180:21
189:2 203:2
206:13,17 212:8
214:16,16 215:2
216:5,19,22
218:13 221:7
222:8 224:3 225:2
227:13 229:6
231:15 238:9
251:13 253:12
254:18 255:4
256:3 261:1
263:13,14,15
268:16 271:4,10
272:2 278:3,4,14
285:4,7 286:13,21
290:18 294:5
295:5,13 301:21
304:2 313:6
314:11 322:18
324:7,15 325:13
325:21,21 326:21
335:15 341:2
357:21 358:10
359:18 363:8
370:13 371:20
374:17 376:11
378:16 379:2
381:6,22 385:8
390:2,11,16 393:8
393:12 395:14
406:9
realm 54:13
reapply 20:14
reason 29:8 46:13
46:18 85:6 86:2
109:3 126:6
156:18 171:16
172:4,10 219:5
224:7 229:14
238:15 240:3
244:19,22 343:7
345:13 367:18
368:1

reasonable 112:19
394:8
reasonably 246:5
reasons 75:2 91:13
114:7 157:2 289:3
358:6
recall 7:8 42:18
247:12 284:7
318:11 335:12
recap 392:4
receive 16:10 26:19
29:13 30:20 39:21
40:1 41:5 61:8
68:12 82:4,5
83:21 96:8 231:15
263:17 266:2
received 7:9 27:3
33:15 40:16 59:3
61:1 68:5 107:4
118:14 157:21
177:22 208:4
264:13 265:13
270:1 273:8
315:15 316:17
336:18 348:2
375:3
receiving 136:22
234:16 316:2
recite 7:13,14
Recognition 14:3
recognize 21:15
23:17 61:10 87:14
270:9 325:8
recommend 117:1
202:12 225:4,17
237:13 240:9
317:13 406:17
recommendation
97:9,11,14 161:18
161:19 162:5,7
170:2 182:14
204:8,10 224:2
225:5 229:17
237:3 280:5 281:5
379:15
recommendations
22:22 25:1,19

32:19 33:17 42:12
55:10 62:14
178:19 211:1
220:18,19 221:1,3
224:13 225:9
247:11 254:16
291:12 344:11
379:5,17
recommended
26:13 185:2 231:4
238:17 280:2
293:7,18 295:12
377:20 408:11
409:6,7,8,8,9
reconcile 26:18
304:11 370:21
record 72:20,21
154:9,10 157:5
186:9 205:18,19
269:15,16 281:22
296:18,22 318:21
333:15 345:8,9
351:22 396:19
recorded 5:18
211:20 341:11
recording 113:1
162:9
records 333:16
401:10
recuse 17:10
red 189:21 225:5
225:10 388:18
redo 125:7
reduced 220:8
301:2 405:12
reducing 96:14
218:19
reduction 180:19
redundant 335:4
reemphasize
370:11
refer 114:4 190:20
213:10 230:4,7
293:8
reference 83:17
219:19
referenced 225:13

references 106:13
189:9
referencing 402:19
referral 230:19
referred 29:22 81:1
93:14 115:14
referring 106:21
107:3 111:12
169:7 230:3
336:14
refers 293:21
306:20
refine 68:7
reflect 67:5 77:2
192:20 250:17
281:2 318:9
340:16 381:14
393:13
reflected 190:4
194:10 396:19
reflection 239:5
358:11
reflective 209:4
401:9
regard 164:20
168:12 249:17
260:20 263:9
265:7 266:14
267:13 320:11
regarding 69:7
84:11 101:2 106:5
158:2,9 165:7
177:2 184:17
186:13 193:8
235:22 334:7
regardless 116:4
134:5 219:1
regards 36:18
131:22 180:17
186:15 281:16
308:22 310:15
regime 7:22 18:22
regional 392:16
register 133:6
regular 271:13
282:5,12
regularly 108:3

regulation 351:21
rehydration 354:1
    354:19 376:9,16
    377:19 378:1,3
    385:13
reimburse 132:11
    409:18
reimbursed 132:4
    224:8 282:4
reimbursement
    132:2 133:4,8,19
    138:22 139:10
    349:6
reiterate 168:10
relate 63:4 329:17
related 13:9 34:20
    35:18 36:12,13
    50:6 62:21 64:4
    121:18 135:7
    161:20 170:8
    204:12 230:22
    297:21 304:17
    329:21 386:16
    398:14 399:15
    400:3 406:14
relates 327:9
relating 18:9
relation 24:2
relationship 126:10
    376:3
relative 376:7
    397:9
relatively 83:2
    217:8 223:17
    245:7 380:22
release 18:11 62:13
    379:16
released 63:7
relevant 7:16,17
    8:7 13:11 59:15
    78:3
reliabilities 148:6
reliability 27:14
    100:21 103:3,9
    146:6 147:9
    149:18 150:9
    167:5 170:19

187:1 191:1
209:22 235:21,22
236:4 239:1 241:5
241:7,11,13 242:3
243:1,8 246:13
264:11,16,19,21
265:3 308:20,22
309:4,4,7,11
331:21 332:16,17
332:22 334:13,16
334:20 335:3,7
350:12 374:1
400:5 402:6,8,13
reliable 42:21 43:9
    241:22 244:18
    257:14 310:14
reliably 243:21
relied 88:13
relies 103:7 236:1
    332:20
rely 88:1
relying 20:11
remain 25:21
remained 394:9
remains 386:5
remarking 206:4
remember 5:20
    32:16 174:9 240:5
    279:9 343:21
remind 5:16 8:10
    39:6 278:11 297:9
    320:2
reminder 410:1
reminders 68:21
    69:6
reminding 320:1
reminds 218:7
remote 107:15,16
remove 172:22
renal 9:6
rendered 276:15
rendering 102:18
    332:8
Renee 1:18 11:5
    46:21 56:12
    272:11 273:2
renewing 95:14

reopen 104:21
repeat 179:17
    186:7 292:11
    335:6
repeatable 186:21
    308:21
repeated 387:7
repeating 26:4
report 26:16,16
    27:7 38:16 40:12
    42:14 63:5,7 67:5
    82:3,11 99:21
    116:14,21 117:12
    128:1 149:12
    157:5 167:4 170:1
    173:15 175:16
    181:12 216:16
    229:11 232:14,15
    234:5 235:12
    237:2 239:22
    250:19 251:8
    297:8 358:16
    372:6,7 381:2
    383:5 396:2
reportable 311:10
reported 100:16
    118:6 202:10
    333:12 389:3,5
    392:22
reporting 11:8
    44:22 45:2 49:16
    51:18 60:3 80:21
    108:8,11 153:5
    154:20,21 160:2
    199:14 208:6
    227:20 252:18
    270:2 281:16
    310:15 364:16
    372:15,16 383:4
    405:7
reports 340:1
    364:1
represent 169:22
    244:10 352:6
representative
    72:11
representatives

24:1
represented 135:11
representing 8:13
    8:14 15:20 345:21
represents 88:21
request 129:15
    136:5
requested 185:1
require 131:12
    136:6 196:22
    207:6 220:3
required 44:3
    113:19 114:5
    129:11 130:16,17
    131:16 132:1,1,5
    136:13 199:1
    207:5 214:18
    270:14 344:1
requirement 66:7
requirements
    80:21 143:12
    320:14
requires 178:10
    209:4 365:22
requiring 131:3
    140:7
research 7:20 9:3,5
    14:13 17:7 139:4
    261:7
Researcher 17:16
reservation 409:15
reserve 409:13
residence 367:21
    367:22 403:17,18
resident 354:15
resource 87:6 90:7
    123:18 185:7
resources 42:3
    55:18 75:3 86:4
    113:9 377:1
respect 25:6 101:3
    237:17 287:22
    372:8 378:10
    384:11
respond 23:3 24:9
    24:14 141:18
    165:7 190:10

257:19 280:20
400:10
responding 23:2
    354:4
response 106:8
    107:8 151:18
    165:22 202:21
    356:21
responses 268:6,21
responsibilities
    143:14
responsibility
    363:4,12 364:21
    370:17,18
responsible 25:13
    82:21 352:4
    378:18 386:12
rest 68:15 162:20
    384:18 408:17
restate 243:11
restaurant 409:14
restoration 118:16
    181:7
restorations 118:14
    119:4
restorative 119:22
restoratives 140:2
restrooms 5:22
result 366:18
results 60:6 119:14
    120:16 134:16
    146:9 150:15
    158:3 191:3 192:3
    226:7 338:22
resume 7:13
review 3:8 21:19
    22:18 23:3 26:12
    26:12 28:3 36:19
    38:8,20 68:19
    96:20,22 146:22
    154:14 211:2
    237:4 248:4 273:6
    273:17 293:22
    294:4 297:18
    302:21 303:2
    318:2,3,7,13
    321:10 323:8,9

San 122:12
Sarah 1:9,12 9:3,21
  22:3 32:12 166:14
  206:3 237:11
sat 8:4
save 315:10
saw 55:7 142:1
  238:19 252:18
  275:3
saying 37:15
  168:16 173:2
  195:10 203:15
  236:20 237:7
  253:15 285:3,21
  294:5 299:3 302:2
  302:16 304:1
  305:4 354:10
  357:2,15 362:10
  365:3,5 385:2
  389:9 401:4
  407:16,19
says 16:19 87:3
  88:12 97:4 144:16
  147:10 184:21
  188:12 230:4
  240:21 329:15,17
  338:4,6 340:11
  358:18 381:21
  389:15 390:7
scale 60:11 137:22
scan 31:18 57:15
  58:1 336:8,13
  338:22 339:6,10
scenario 301:4,10
  353:15 386:4
schedule 39:16
  66:6
schedules 39:7
  212:11 295:11
School 2:4 18:7
science 15:4 229:7
  280:6,8
scientific 27:10
  38:16 70:9 152:1
  167:3 172:14
  185:18 186:14
  187:18 193:1

246:11 306:17
345:20 371:9
399:9
scope 37:13 146:8
  150:14 191:3
  192:3 287:5
score 103:15
  141:20 144:16
  145:1 149:19
  152:11 202:11
  243:14,17 336:17
  338:15 387:11,21
scored 336:22
  338:17
scores 187:7,10
  201:2 202:8
  209:22 241:14
  300:14,16 303:21
screen 126:4 146:2
  160:19 166:9
screening 35:3,14
  36:1,3 37:8,9
  88:10 122:1
  294:12
screenings 295:12
script 166:9 167:1
  175:9,22 210:14
  232:2,5
se 221:1 401:16
sealant 84:22 85:2
  85:15 87:7 96:8
  97:4 98:10,19
  101:4 106:7 107:5
  108:10 110:4
  121:6,10 130:19
  132:20 133:14,21
  134:3 136:7,13,19
  201:18 210:2
  211:18 274:13
sealants 4:3,6
  93:18,22 96:2,13
  97:4 98:18 109:6
  110:13 114:11,22
  133:16 136:8,22
  141:13,16 143:19
  162:10 180:19
  204:20 209:6

211:15 308:5
sealed 98:15,16
  101:21 120:20
seated 73:1
seats 70:16
second 20:14 27:10
  33:9 55:17 146:21
  148:4 206:10,20
  208:16 213:6
  279:13 297:15
  300:22 314:19
  323:1 344:8
  345:14 351:12
  376:21 403:2
secondary 346:16
  349:2 350:2
  351:15,18 352:6
  366:21 392:8
  399:13 400:21
secondly 395:6
seconds 127:13
  156:7,8 157:9
  163:14,17
section 68:19 70:13
  88:7 116:9,13
  225:8 235:20
  242:22 243:4
  248:18 249:12
  261:14 262:12
  264:10 336:13
  338:4 339:9,12
  398:11
sector 77:6 80:2
  115:22 139:17
  253:11,13 386:12
sectors 194:6
  245:14
see 21:11 32:21
  34:2 35:12,21
  39:1 43:16 45:12
  47:3 48:5 53:17
  56:3,21 58:5,12
  82:3 85:20 102:1
  105:22 112:2
  118:13,21 119:14
  120:16 126:4
  142:10,16 145:8,9

147:12 149:21
158:22 160:19
161:6 171:12
174:12,22 175:1
178:20 180:4
189:4 192:21
194:19 200:22
201:22 209:17
224:17 230:14,14
230:15,16 242:21
243:19 251:6,10
255:2 257:6,6
265:20 270:17
273:14,14 275:1,5
276:22 286:3
287:15 291:22
292:8,9 299:2
306:3 309:21
322:21 325:17
327:16 331:21
332:15 336:16
350:22 353:8
354:2 365:4
368:15 385:1
386:17 387:5
397:2 400:8
409:19 410:3
seeing 114:20
  196:7 208:22
  256:3 259:17
  269:8 311:15
  386:19
seek 187:8
seeking 194:9
seen 83:22 101:17
  141:15 293:10,19
  343:6
segment 116:2
segmentation
  81:20
segments 95:4
  214:8 228:13
selected 22:14
  23:22 53:20 54:2
  215:17
selection 27:20
  49:15 59:16 63:10

self-assessment
  58:12
Sellers 2:1 15:3,4
  363:21
send 68:2 124:15
  124:18 221:11
  304:8 337:3
  354:20,21
sending 353:21
sends 353:17
  354:12
Senior 2:7,9 9:3
  12:22 13:19 15:10
  19:20 47:16
sense 20:10 102:13
  103:2 129:16
  170:8,18 178:11
  226:22 251:20
  277:13 294:19
  304:19,20 332:13
  348:16 353:2,6
  357:12 373:22
  378:22 381:14
  387:6 397:15
sensitive 347:13
  376:1 378:6
sent 26:22 166:12
  354:18
separate 102:14
  130:9 202:8 289:1
  289:1 350:6
  359:18 369:22
  409:17
September 40:19
  40:19
sequence 286:15
series 128:21
  168:15 260:21
  305:7,19 350:8
serious 143:6
  263:19
seriously 139:5
seriousness 279:9
serve 8:15 18:14
  22:14 46:14,19
  234:22
served 223:3

service 101:3
102:15 105:9
114:5,13,22 133:7
144:21 208:16
213:16 224:12
234:16 235:6
259:19 265:21
266:3 271:6 273:8
273:18 275:12
287:8 315:12
341:10
services 1:13 4:11
4:12,13,14,16
10:18 17:15 31:2
32:14 52:21 76:8
77:12,13,21,22
80:18 81:21,21
82:5,6 83:5,12,12
84:7 107:12,17
108:22 109:10
115:10,11 130:12
132:5 139:4 145:9
196:13 198:1
207:17 210:9,12
214:18 215:4,7
216:21 233:13
239:18 259:5,8,9
259:17 260:14,14
260:18 261:7
262:15,15,16
263:17 264:13
265:11,13 266:2
269:2,2,19 271:2
271:13 272:20
275:20 285:19
286:12 287:3,10
287:16 290:10
291:1 315:21
316:3,8 324:10
329:7 332:7
347:15 348:1,2
serving 11:15 15:8
28:7 70:1
session 270:11
set 42:3 55:10 59:8
62:14,21 63:2
67:8 69:4 72:13

73:12 74:21,22
77:1,8 80:10 83:9
119:11,12 131:4
135:19 142:8
143:10,11 197:18
219:6 221:20
251:11 288:16
326:20 337:9
361:21 363:19
384:20
sets 50:3,15 120:15
123:2,3 293:3
setting 50:20 52:4
52:10,22 58:21
93:2 109:15
125:16 370:1
376:12
settings 14:20,20
16:18 31:3 34:18
50:5 51:3 189:11
277:20
seven 183:16
235:18 248:11
265:4 394:3
Seventeen 242:20
severity 123:19
185:7
sex 383:8
shape 388:21
share 173:19 174:3
322:3
shared 170:19
171:12 363:11
SharePoint 168:3
190:20
sheet 106:12
sheets 106:12
shift 325:22
Shore 1:22
short 67:22 131:11
206:1 343:22
360:12 408:8
shortest 317:10
shots 294:11
should've 37:17
show 190:13
228:11 241:14

248:5 301:12,19
311:13 317:15
369:14
showed 129:21
212:2 253:9 273:8
280:4
showing 48:1
158:21
shown 92:14
105:15 277:2,5
342:14 377:10
395:21
shows 209:12
273:20,22
shrinking 115:20
side 46:16 83:19
133:19 140:6
189:16,19 214:3,4
242:4 243:8
245:13 247:5
264:14 306:4
349:7,7 351:16
380:5
sides 240:17
sign 18:11
signal 47:12 263:18
significant 31:12
84:8 173:11 188:6
229:4 252:18
253:9 286:4
352:22 392:21
398:12 405:9
silence 19:6
similar 53:4 57:22
84:12 110:19
120:13 170:14
176:10 179:10
180:16 206:14
210:1 229:21
235:1 244:13
294:19 325:3
366:9 389:19
similarly 396:8
simple 276:17
380:11
simply 74:12 75:16
75:22 79:22 84:13

88:8 110:17 112:4
112:7,9 118:16,19
122:4 130:1,3,19
140:12 176:11
179:13 195:18
196:22 209:12
213:17 215:21
223:3 235:5
239:19 244:5
259:17,19 270:16
307:21 327:15
341:3 399:20
single 7:14 95:11
202:11 324:2
sister 210:11
sit 19:5 67:21
site 61:8 168:4
190:20
sites 12:3
sits 383:1
sitting 8:10 24:8
89:19 205:21
339:19
situation 69:10
236:11 295:4
356:8 360:14
six 9:10 34:14,16
37:2,7 73:19 75:2
75:6 92:18 93:12
156:12 160:2
199:14 209:15
225:6,10 234:10
250:7 260:6
266:11 268:8
282:5 303:9 334:8
334:9 346:1
392:22
size 108:14 111:2
sizes 373:13
skew 140:11
skip 72:9 103:11
skipped 126:14
sliced 219:8
slide 32:17 48:1
183:5 212:2
slides 124:3,4
153:21 159:16

slightly 222:17
slip 319:11
slips 9:15
slow 82:14
slower 384:7,10
slowly 133:17
small 160:19 245:7
245:15 373:13
378:4
smaller 326:14
smoking 47:8,8
snap 123:12
social 31:4 33:12
33:19,20 35:4,17
36:14 38:1 52:20
53:11 55:9 65:2
358:3,6 362:16,21
367:10 369:16,19
370:6 373:5 380:3
384:1 386:7
Society 8:5
sociodemographic
257:7
socioeconomic
256:16 375:13
376:1 377:7,9
380:12 393:15,19
394:4
softens 223:16
software 161:3
solely 8:1
solutions 377:19
378:3
solving 307:21
somebody 81:12
108:19 109:3
170:22 217:13
287:14 301:8
324:18 355:9
363:4 385:11
somewhat 52:7
57:22 103:2
151:21 257:12
312:6 314:13
368:14 377:6
soon 87:15
sorry 9:13 12:17

14:7 19:19 55:5
68:2 76:12 105:2
121:21 126:22
140:21 158:10
173:22 177:5
181:16 182:16
183:22 194:4
198:2 201:5 202:4
205:16 243:10
247:18,19 257:18
262:7 296:5,12,19
297:1,8 299:4,7
303:16 315:11
319:10 329:16
337:22 340:9
342:2 354:9 395:2
400:6 409:22
sort 21:3 29:21
43:12 45:21 47:2
47:7 49:18 60:17
62:20 63:19,21
66:20 77:14 82:19
109:12 114:7,12
114:21 117:13
122:16 133:20
134:19,20 137:8
141:11 142:18
172:5 173:1,3
190:2 194:9 206:6
212:8 214:19
219:6 221:4 227:6
227:13 229:4
230:21 236:12
240:13 245:10
253:11,11 255:10
265:16 270:21
271:7 272:2 276:8
301:7 306:1
313:19 316:12
335:3 352:17
355:8 360:15
376:21 384:5
385:5 386:15
sound 304:13
sounded 280:9
source 108:21
193:11,15 245:10

287:1 291:5
310:12,14 400:1
404:14
sources 92:12
102:7 150:18
155:19 193:6,6
198:7 234:22
266:15 270:6
south 367:9
southern 388:7
space 42:9 43:13
44:11 87:14
spaces 88:8
span 31:2 34:19
50:4 216:12,22
217:8 271:4
Spangler 2:2 13:3,4
14:6 99:6,14
153:12,16 281:10
282:18,22 283:3
speak 5:20 19:2
108:1 171:5
174:10 222:1,6
241:2 290:6
302:19
speaking 29:7
104:19 238:16
305:11
speaks 74:10
244:15 369:17
spec 106:12,12
special 127:8
291:17,18,22
specialist 16:9
specific 15:1,16
16:16 50:6,20
64:22 84:22 85:3
85:4 97:3 100:10
106:22 123:15
132:16 148:21
149:9 185:4
186:12,19,21
209:9 272:19
275:7 293:6
308:21 309:1
310:15 313:12
321:1 330:7 331:7

336:21 340:5,15
343:2 369:7 395:4
404:12 407:11
specifically 30:21
43:13 53:18 54:16
106:15 128:19
173:6 185:1
273:21 287:11
329:7 332:15
338:10 402:19
specification 361:1
specifications 25:2
101:1 128:18
146:7 147:22
150:12 191:2
192:1,7 235:22
360:8
specified 45:8 47:9
69:8 103:5 148:8
240:7 332:19
358:14 366:1,14
407:21
specifies 367:22
specify 281:17
286:16
specs 337:8
spectrum 219:2,2
406:16
speculation 79:1
speedometer 384:6
spend 86:3
spending 95:15
spirit 19:11 254:15
split 250:16 296:3
splitting 215:1
265:10
spoke 179:17
sponsor 78:5
sponsored 115:22
sporadic 272:3
spot 335:12
SR 182:11,15
staff 2:6 19:9,10,16
22:9,16 25:13
36:9 71:4 74:11
165:7 409:18
stage 9:6 69:4

113:8 226:13
229:3,10 384:20
stages 336:5,11
stakeholder 49:14
57:1 63:22 333:21
stakeholders 23:14
29:14 48:21 56:19
57:13 78:10 334:2
stand 101:15 201:4
201:9 202:7
standalone 79:9,20
129:20 130:1
standard 103:7
229:21 332:20
349:1
standardization
28:19 172:13
standardized 30:11
33:7 44:10 348:21
standards 13:1
23:5 26:9,11,22
33:7 264:16 401:7
standing 5:7 15:22
20:4 22:13 70:2
180:13
standpoint 181:1
201:10 218:16,17
229:20 255:21
290:7 291:10,16
292:8 310:17
stands 279:6
star 205:9 391:5
start 22:21 37:15
54:8 60:15 64:1
70:14 72:10,17
73:6,13,16 74:8
77:8 91:2 92:8
93:11 94:1,21
108:17 116:10
121:14 123:7
131:3 133:17
147:12,20 154:16
164:17 180:2,6
208:10 215:19
218:6 224:5 248:9
250:4 256:12
262:4 263:2 285:9

341:8 354:19
362:2 366:22
370:16
started 55:8 73:2
78:7 261:9 283:6
283:7 289:14
350:6 355:20
starting 20:17 51:8
63:14 80:8 176:6
221:19 238:8
410:2
starts 146:2 246:15
249:7 290:12,14
354:2 365:19
state 2:1 14:14 15:6
18:10 45:9 46:4
60:19 79:11 95:19
107:14 109:5,15
115:4,19 120:15
209:9 228:12
233:19 252:16
319:12 334:1
348:9 392:17
401:6
State-based 43:19
stated 96:11 180:16
198:22 316:21
340:7 358:15
statement 240:20
281:6 366:2,7
392:6,11 399:11
399:20
statements 24:15
399:11
states 77:22 79:13
80:21 81:16 83:3
90:3 94:12 95:10
102:17,22 108:2
114:6,14 115:7
119:15,16 130:1
134:15 143:12,18
143:21 144:1
199:1 212:8
224:11 228:2
248:21 266:18
267:15 317:16
318:7 332:10

348:10,11 372:16
405:6
statistical 103:4
148:7 332:18
366:15,17 367:2
statistics 176:19
209:21
status 66:9 98:11
102:12 112:21
194:20,20 195:1,2
195:2 213:8
233:13 271:19
329:10 356:2
400:21 403:5
stay 62:4 64:17
292:4 344:5 352:8
355:20 356:10
360:16 390:20
398:14
stays 356:14
360:12
steep 20:6
steering 1:3,8
13:17 40:21 173:7
step 56:9,16 58:11
179:16 276:13
302:21,21 315:21
325:4 339:16,16
339:21
stepped 324:17
stepping 6:16
steps 26:6 48:14
340:1
Steve 31:15 32:1
sticking 207:10
stimulated 136:5
stink 365:16
Stocks 72:2
stop 99:2 101:8
165:18 342:7
stops 144:8
Stoto 2:3 71:21
319:3,7,14,17
324:4 326:19
335:11,20 336:15
336:21 337:22
340:4,10,21 341:5

361:5,19 363:8
374:22 379:7
393:4 395:13
396:18
straddling 306:2
straight 75:7 324:1
straightforward
283:18 310:18
strands 375:20
376:6
strategic 47:17
59:20
Strategies 30:17
strategy 13:8 15:5
20:21,22 48:17
50:7,18 51:1
62:22 109:22
stratification
150:16 216:14
217:6 229:9 382:7
382:12 400:12
stratifications
216:15
stratified 383:7
stratify 227:19
383:8
stratifying 219:14
streamline 168:7
Street 1:9
strength 97:9
220:18 221:2
strengths 58:15
59:5,10 175:1
stress 7:21
stretch 327:4
stride 269:5
strike 77:15
strikes 324:12
393:7
stringent 381:6
stroke 372:13
strong 32:18 57:20
85:9 87:17 94:6
294:18 295:1,6
375:5 376:8 380:3
393:1
stronger 322:11

strongly 85:13,16
137:5
struck 194:17
326:21
structure 34:9
76:21 127:3
137:13 138:22
232:15 262:1
323:15 367:12
386:21
structured 369:1
structures 126:11
struggle 41:13
42:18 236:18
278:10 387:8
struggled 44:16
45:18 151:10
struggling 170:17
172:12 277:14,14
283:16
STS 376:4
stuck 294:15
studies 180:18
210:21 222:15
247:12 262:17
318:9 369:14,14
369:22 377:8
study 301:18
318:15 375:18
stuff 99:11 222:8
sub 152:7
sub-criteria 116:20
242:11
sub-criterion 149:9
149:12 166:22
171:22
sub-topics 34:20
subcommittee
64:12
subcontract 79:19
subject 356:1
subjectivity 137:18
172:16 173:1
submission 40:8
75:4 149:13
219:17 242:22
254:13 302:10,13

302:18
submit 38:11 75:1
203:8 213:2 281:3
303:4 348:19
submits 108:19
submitted 23:2
25:2 26:12 37:2
73:20 75:6 127:4
127:12 147:21
182:11,13,20
224:17 297:18
400:8
subsequent 39:7
136:12 287:16
324:7
subset 258:3
272:18 309:16
subsets 51:3
substantial 251:3
333:18
substituted 160:20
subtle 258:12
successful 60:11
376:15
sufficient 112:7
149:4,14 158:21
sugars 91:18
suggest 65:17
92:22 93:9 303:9
322:19
suggested 51:12
52:18 64:15 65:12
84:20 105:13
188:9 308:20
342:12 375:13
suggesting 302:10
323:1 379:19
suggestion 137:9
280:21 327:19
suggestions 24:18
24:20
suggests 122:6
135:9 222:4 316:6
323:2 394:4
suitability 200:8
204:6,18 251:18
258:20 259:1

268:15,18,22
312:11 344:3
406:3 408:4
suitable 44:22
summaries 222:15
summarize 62:11
133:10
summary 225:8
329:16 409:5
summing 239:8
supervising 82:21
supervision 80:19
81:17 107:2,13,15
107:16 109:13
supply 377:2
397:13
support 63:9 66:21
87:4 88:4 94:19
96:20 98:20
149:16 180:18
215:10 278:16
295:6 309:18
317:6 335:15,16
358:21 377:15
supported 85:13,16
208:18 210:21
211:1 228:4 237:7
333:14
supporting 376:9
supports 70:7
126:9 358:20
supposed 132:8
151:12 200:14
239:5 240:6
358:20 373:21
378:19
supposedly 390:22
sure 29:9 30:18,19
32:2 36:10 40:7
55:6 58:1,17,21
59:12,22 60:5,17
71:5,9 85:10 96:5
101:13 106:9
113:10 123:11
133:17 139:15
147:3,8 158:19
159:3,17 164:9

179:15 185:22
186:2 187:4 189:8
201:13 202:21
214:10 215:18
232:1 237:1 238:1
238:3 242:2
243:13 244:21
254:9 272:15
302:16 313:16
316:2,15 330:3
335:1,4 336:2,17
345:19 351:8
357:13,20 358:16
368:19 385:5
386:2 395:19
407:8
surpasses 369:16
surveillance 251:10
suspect 131:15
390:19
suspicion 91:22
sustain 60:13,18
sweeping 66:12
switch 163:1
synopsis 167:13
synthesis 303:11
system 1:21,22
10:17 30:22 32:3
32:4 45:21 51:19
75:15 82:20 86:10
110:11 112:8,10
113:1 117:12
130:11 131:8
139:6 141:6,9,12
142:9,15 189:10
193:13 194:8,14
195:4,8,14 196:15
197:1,11 202:1
203:17,22 213:3
214:9 217:22
230:10,12 239:15
275:9,14 276:5
327:17 359:10,12
359:16 361:15
362:8,15,20 363:2
363:5 364:11,20
365:2 370:11,12

370:17 371:11,14
371:15 378:7
386:11 389:14
393:14
systematic 97:15
211:2 223:14
252:22 297:18
298:5 302:6,21
303:2 318:6,13
364:4
systemic 381:14
systemized 303:13
systems 82:15
93:18 118:10
130:9 135:16
155:1 213:19
306:20 307:1
394:5
systemwide 52:1

T

t's 337:8
T-A-B-L-E 3:1 4:1
table 1:18 8:17
11:6 24:6,8 32:12
42:15 43:4,7
70:17 89:20
102:19 152:4
181:14 241:14
243:11 248:6
339:19 362:3
374:9
tables 243:1
tackle 371:14,16
391:12
tag 177:6
take 18:10 21:18
22:9 30:9 48:14
49:5 54:6 61:6
65:22 73:20 76:10
114:2 131:20
154:1,2,7 164:4
175:13 205:14
212:11 225:2
247:1 253:20
269:8,12 276:3
285:22 302:12

337:5 339:17
367:5
taken 177:12
265:22 372:1
takes 75:3
talk 32:22,22 39:16
39:16 40:5 41:3
41:20 47:18 55:16
56:11 65:9 77:11
105:21 167:4
169:11,18 177:10
178:3,16 209:14
215:12,16 217:11
218:10 232:6
247:20 248:1
286:2 306:18
349:1 369:7 380:5
talked 65:8 66:18
95:9 101:6 158:6
177:17 188:22
265:15 318:12
332:11 338:16
403:3
talking 29:6 56:5
149:10 150:9
178:17 179:21
189:12,22 236:2
248:22 260:1
293:4 298:2,12
332:16 339:9
347:4 349:19
351:14,15 361:6
369:8 383:11
talks 188:1
tanked 353:22
tap 91:14
target 86:3 113:9
142:14 258:3,5
targeted 33:14
110:12
targeting 258:4
targets 59:17
task 29:17 51:6,11
59:15 63:14
224:11
tasking 187:16
tax 42:21 43:20

66:9
taxonomy 102:18
332:8
teaching 289:4
team 17:13 74:9
119:8
teased 188:11
technical 12:22
17:12 90:14
technically 133:12
teen 254:21 255:5
teeth 97:6 101:21
120:20 121:4
201:19 221:16,17
222:19,20 223:9,9
223:22 226:15
teleconference 2:18
telephone 64:9
205:10
tell 8:17 19:6 97:19
121:4 219:14
220:11 221:3
225:3 301:5 358:8
373:9
telling 87:18
ten 39:1 58:6 67:3
75:1 92:6 93:6
114:17 200:4
249:9,10 250:7
304:4 345:2 378:5
ten-minute 269:12
tend 255:6 286:8
377:5
tenet 32:17
tentative 53:21
term 9:16,20 10:3
10:20 15:2,8,17
16:5,13,19 17:1
18:16 20:14 22:15
81:4 110:2 200:20
202:5 292:2
319:13 363:1
terms 28:7,8 37:19
39:11,19 49:19
50:1 52:12 53:2
53:14 54:12 58:13
59:21 60:10 65:1

75:14 84:6 85:22
87:7 89:2,3,7
108:4,5,7 109:19
112:21 113:1
115:2 130:15
137:12 138:8
140:6 147:1
154:20 187:11
203:17 208:16
216:7 220:20
223:6,20 228:18
230:1 231:14,16
245:5 247:21
252:19 253:14
255:22 259:17
260:1 270:7,14
272:6,8 278:1
283:11,22 285:20
295:10 315:22
321:10 325:8,13
338:17 339:9
355:2,14 359:3,21
362:12 369:18
373:15 397:9
407:19
Territorial 2:2
15:6
territory 312:6
test 125:1 148:7
245:13 313:1
334:5 337:2
tested 30:11 148:6
381:8 402:4
testing 25:3 27:13
27:14 44:3 89:6
90:2,8,15 103:3
103:13,13 112:14
119:8 120:14
121:9 134:14
146:7 148:11,16
150:13 176:18
187:8 191:2 192:2
236:1,4 242:9,11
243:7 245:6
264:16 330:8,9
332:16 333:2,4,7
337:4 350:9

402:20
tests 103:4 332:18
Teutsch 31:15
Texas 105:11,17
158:18 233:19
245:3 249:14
267:16 342:10
text 189:21 338:18
thank 7:6 11:4 17:2
18:18 19:14,15
22:7 28:4 47:21
61:9 68:10,12,16
74:7 76:12,13
84:5 89:10 117:8
121:20 157:14
161:12 181:22
183:21 198:15
202:2 205:20
229:13 234:2
246:10 248:6
262:20 267:1
269:4 272:11
300:3 311:14
312:4 319:3 322:6
330:11 335:8
345:2,4,6 349:16
351:4 352:14
382:4 396:20
403:19 408:12
thankful 360:3
thanking 73:16
thanks 22:10 68:13
71:15 207:10
309:5 319:22
394:14 398:19
403:22
theirs 317:19
themes 377:14
therapists 83:1,2
therapy 118:16
they'd 354:20
thing 7:14 11:6
13:15 16:19 20:3
67:17 76:5 104:17
130:6 139:14,16
144:15 146:1
159:7 169:4,7

170:22 173:2
176:16 190:5
195:19 201:20
209:8 211:12
213:6,11 226:8
245:5 252:15,20
260:4 261:4
270:20 285:13
288:1 289:22
292:11 300:19
312:16 316:4
325:7 326:19
327:6 338:16
357:16 371:14
372:12 375:15
382:19
things 7:16 45:13
46:10 56:4 66:14
74:4 81:14 93:21
109:13 111:10
114:15 133:19
154:11,12 162:22
164:14 165:18
166:6 170:16
171:12 174:22
177:14 178:11
190:14 195:12
226:19 229:3
236:22 240:13,16
251:21 252:9
253:17 280:14,18
286:20 289:2,4,15
301:7 312:22
314:8 331:22
357:18 358:21
359:4 367:13
368:5,6,16 372:4
380:11 383:6
386:22 390:7
395:4
think 11:6,14 19:1
19:3,4 21:1,20
22:6 30:1 35:19
42:4 43:6,9,10,14
43:21 44:5,6,9,15
44:17 45:1,19,22
46:1,6,18,21

49:19 50:16 51:8
51:13,22 53:5,15
54:19 55:15 56:8
61:13 63:14 64:5
64:20 65:15 66:12
66:22 67:12 69:1
70:2 71:2,20 72:6
91:22 92:11 93:22
94:10 99:4 101:9
104:14 106:8
108:18 109:2,22
110:21 111:11
116:5 121:14,17
123:22 124:9
126:5 128:8 129:4
131:11 132:21
133:2,15 134:4,12
135:3 136:14
137:7 139:2,3,7
143:6 147:20
149:20 152:9
154:11,19 164:13
164:15 165:8,22
166:3 168:11
170:5,5,7,16
171:7,10 172:1,3
172:20 173:1,21
175:21 177:14
178:15,19,22
179:20 180:21
190:6 198:21
201:10 202:15,16
202:20 203:19
204:1 206:5,10,14
206:21 207:19
214:22 216:11
218:9,21 219:9
220:3 221:10,20
227:4 229:2,9,14
238:16 240:8
241:10,13 242:6
243:6,10 244:12
245:18 246:5,8,20
249:15 250:22
251:19 252:7,15
252:21 253:15,21
254:6,19 255:12

255:17 256:5
257:1,4,15 258:17
269:5 270:19,20
272:14 275:1
279:8 286:6
288:10,12,12
290:3 296:12,20
299:22 300:6,14
301:3,11 302:13
302:15,17 303:22
305:10,11 306:3,8
312:7 313:4,14
314:4 316:11
321:6 322:8,10
323:6,8,15,21
324:2,9 325:7,8
325:19 326:8
327:13 332:4
335:12 343:2
344:17 352:10
353:2 356:22
359:7,12,19 360:5
360:9 361:16,19
362:7,17,19 363:1
363:1,6,9,18
365:18 366:8,15
367:2,4 368:9,13
368:21 369:3,5,6
369:10,10 370:7
370:12 371:10,12
371:20 374:22
375:5 376:8
378:10,13 379:13
379:21 380:1,16
381:3,13 383:10
383:14 384:3,11
384:15,19 387:13
387:17 388:13,19
389:19 390:4,7,15
391:1 394:7
395:20 399:2
400:17 401:2,15
402:2 406:6,17
407:6,6 408:8,15
408:18
thinking 52:9,21
56:5 57:8 65:2

66:20 149:3
170:22 201:3
213:6 218:13
352:11 368:2
370:16 386:1
406:12
thinks 242:18
third 35:20 66:17
108:13 147:10
Thomas 1:9,12
thought 18:19
44:20 49:21 65:4
74:5,14 76:10
136:5 153:16
214:1 234:19
276:2 288:7 302:3
326:9 327:2 363:3
thoughts 137:1
171:4 173:19
174:4 252:2
threat 334:10
threats 103:16
150:15 192:3
333:10
three 10:22 11:2,18
14:7,8 17:13 20:2
30:17 38:14 48:1
48:18 52:15 62:17
76:19 92:22
104:17 114:9
117:11 118:13
121:22 124:1
127:11 128:6
129:9 135:13
146:12,17 150:20
151:2 153:10,16
156:2 159:6 160:2
160:9 162:6
182:20 184:7
185:9 191:5
192:10 194:21
197:8,12 198:12
199:13,20 204:22
207:3 209:15
212:9 225:6,10
239:19 244:13
246:18,20 259:3

282:13 284:8,20
317:11 319:12,20
326:1,1 405:6
threshold 248:15
387:2
thrown 305:14
Thursday 61:4,6
68:2
tied 274:2
ties 60:4
time 13:14 15:2
19:2 21:20 23:16
25:15 38:4,7
40:20 43:11 49:6
60:14,18 68:1
75:3 81:4 85:20
89:11 91:8 92:20
99:8 104:18
112:18,19 115:8
128:12 131:14
134:2 135:14
136:21 137:2
145:16 146:13
152:12 163:3,7
179:17 186:9
187:7 194:19
195:8,9 196:4,20
199:5 205:8,12,22
212:4 218:21
236:7 237:3
249:18 251:12
253:5,7 254:8
255:18 256:2,19
257:5,13 279:5
282:10,16 311:13
315:10 316:9
325:17,18,20
339:8 351:5
354:19 369:9
383:15,18 386:19
391:8 396:14
405:10
timelines 21:21
timely 96:12
347:15
timer 127:13 146:2
times 26:1 29:18

94:17 168:14
174:10 206:16
240:12 396:11
tinker 238:20
title 260:13,16
269:18 327:18
tobacco 42:21
today 8:7 9:12
16:13 18:1 37:20
40:11 43:16 48:6
49:5 61:17 64:10
69:5,21 70:6
76:15 88:18 89:19
132:21 140:16
265:18 266:16
279:8 319:6 347:7
366:4 409:2,5
today's 166:13
Tom 8:19 71:12
91:3 214:13
237:10 269:7
386:16 391:21
tomorrow 32:21
37:21 65:18
178:16 346:1
347:5 384:19
390:18,21 391:3
410:1
tomorrow's 345:15
tonight 409:3
tons 174:16
tool 122:1,15,15
228:1
tools 122:9
tooth 85:4 87:2,5
92:17 96:15 97:7
101:4 102:4,4,9
120:2 179:14
186:19 292:6
top 48:5 105:21
116:1 133:21
topic 20:19 50:6
53:1 63:4 241:3
279:1 397:16
topical 4:9 207:15
208:5 209:7,10
219:4 223:2,7,21

224:14 238:18
259:4
torn 236:12
tossup 352:17
total 32:8
totally 84:16
329:20
touch 194:7
track 201:22
325:10
tracked 287:17
396:1
tracking 293:18
traditional 46:7
49:18 51:10,16
113:5 363:3
traditionally 49:21
63:9
trained 93:10
trajectory 93:2
transcends 215:14
transcribed 5:18
transcript 126:3
162:9 175:15
transfer 399:16
transferred 346:19
transfers 354:5
transformed 79:2
transition 225:20
translate 174:21
transmit 113:16
transparency
160:1 199:12
transparent 60:6
travel 370:4,5,7
treated 140:19
142:6
treating 380:8
385:9
treatment 50:11
53:8 119:22
238:18 271:15,20
274:2,3 276:8,12
276:15 284:21
285:6 287:4,9
288:10 289:2,9
290:10,13,21

317:2 347:19
352:9 355:8 373:4
376:10
treatments 118:19
tremendously
257:16
trend 253:16
325:20
trends 252:13
trial 294:1 301:19
303:13
trials 97:16 392:22
tried 85:10 159:15
195:12 219:11
283:8
trigger 190:16
219:3
triggered 213:22
troops 371:6
true 47:12 279:8
285:15 368:13
truly 43:7 254:11
294:13 305:17
try 63:14 64:17
75:8 78:16 80:4
129:14 139:5,8
143:13 144:2
174:18 214:6
257:5 258:10
286:22 288:22
290:11 345:11
384:2 391:11
392:3
trying 6:9 29:8
41:21 44:9 48:20
50:20 51:22 52:12
53:14 58:2 60:1
62:4 63:18 64:6
66:22 92:4 95:20
116:5 121:1
124:19 141:2
143:3 149:20
152:6,16 157:8
158:15 174:17
201:21 212:10
216:20 224:2
228:5 272:9

287:20 306:7
326:22 335:11
339:2,10 343:5
369:22 370:13,14
370:21 371:5
378:19 390:4
TUESDAY 1:5
turn 5:9,20 7:4
20:16 28:1 40:5
47:16 68:14 73:14
76:9 84:4 90:20
104:19 145:15
202:17 351:2
turned 91:19
turning 342:8
turns 348:13
370:17
Twain 279:4
twenty 34:14
twenty-four 34:16
twice 211:19 282:5
313:22
two 6:4 9:16,20
10:4,9 12:5,13
13:2 18:1,10
20:13,15 22:14
29:6 33:10 35:20
35:21 49:7 60:9
62:20 73:14 74:17
74:20 80:3 82:7
82:10 84:21 90:3
101:22 110:21
111:10,22 118:5
120:15 123:22
126:12 127:10
128:5 146:11
148:4 150:19
151:2,9 153:9
156:1,6 157:8
160:8 161:22
173:12 182:20
183:13 184:6
185:8 186:21
191:4,9 192:9
198:11 199:19
203:4,22 204:13
206:13 208:5

209:10,17 213:12
214:12 222:2
226:19 227:3
233:1 244:12
246:4,16 250:8,8
251:2,4,7 263:5
266:12,18 267:15
267:15 268:5,20
271:17 277:8
280:14,18 282:13
300:21 301:14
306:20 311:9
315:15,21 316:3
316:18 317:5,9
319:12,18,20
320:8,10,19,22
322:13 323:3
324:7,7 325:6,11
326:1,1 339:22
341:4,5,6 345:18
345:22,22 347:7
349:20 350:6,10
350:21 356:3,6,11
356:15 359:6
360:1,4,6,14
370:4 375:17,20
376:6 377:14
384:16 395:4,8
402:18 409:6
two-thirds 112:2
two-year 321:5
340:20
type 70:10 173:2
231:18 259:22
289:7 377:15
407:13
types 43:2 48:9
49:20 82:22
109:20 112:15
120:13 138:3
223:15 228:21
284:20
typical 52:22 53:8
56:7 70:10
typically 25:11
79:17 81:18 115:9
137:20 139:21

213:7

___

U

U.S 92:21
UC 2:15 346:6
UK 317:7,9 318:2,7
ultimately 139:12
280:3 371:22
unanimous 334:1
uncertain 206:16
unclear 45:19
uncomfortable
157:2 313:10
362:7
underestimate
239:7
underlying 221:18
228:16 243:22
350:17
underneath 323:16
understand 141:3
164:19 165:14
171:11 200:19
203:3 214:7
216:20 217:7
226:9,17 272:16
284:12 287:21
290:18 300:12
356:2 393:4
understandable
153:4,7
understanding
91:6 133:11 147:7
165:20 203:16
221:15 261:1
263:16 306:5
321:11 371:19
379:16 385:5
understands 59:22
understood 361:10
363:13
undertaking
374:11
underway 65:13
unfair 362:17
unfortunately
91:15 160:22

292:13 315:20
395:22
uniform 348:18,21
unintended 160:6
199:17
unique 260:4
unit 291:18 353:14
United 224:11
units 359:22
universal 33:3
universe 78:3
133:14 385:6
University 1:14 2:3
2:4 14:11 17:5,17
89:20 122:11
319:8
unsealed 121:5
untangle 227:13
untreated 331:4
unusual 77:15
unwell 258:6
update 318:22
397:18
updates 38:12,13
upper 255:5,14
uppercase 6:11
upstream 33:19
52:13 53:11 56:6
upwards 113:16
140:19
urban 14:12 383:2
396:9 397:11
urgent 291:20
350:20 376:13
usability 27:17
38:18 105:10
153:4,17,19
157:17 158:9
159:22 167:10
198:21 199:3,11
200:3 249:13,21
250:1,6 267:21
268:1,7 311:8,15
311:17,22 312:17
343:10,13,17
405:6,14,16,21
usable 239:14,21

usage 380:17
use 11:11 18:12
27:17 29:19 30:3
38:18 41:22 42:4
51:12,15,22 52:15
52:18 59:16 63:13
66:18 69:14 86:18
105:10,13 119:11
119:12 120:12
122:8 123:18
130:10,10 131:7
132:14 134:8
135:13 137:3
139:8 143:3,16
148:15 153:19
157:17 158:3
159:22 160:1
161:4 167:9 181:6
185:7 186:20
196:1 197:1 198:1
198:21 199:1,3,5
199:12 200:3
201:12 208:10
211:22 215:6
217:5 219:5 221:6
224:14 227:16
228:2,3 231:12
233:13 239:5,7,22
249:13,14 250:2,6
265:10 267:13
268:2,7 271:13,14
271:21 272:9
280:12 287:16
311:9 312:17
314:22 316:8
325:15 339:1
342:12 372:2
373:18 374:8,13
374:19 376:17
378:2 379:11
386:17 389:2,10
405:9
useful 153:5,7
255:22 300:13
325:21 327:6
363:19 369:11
381:16

user 6:9 106:13,15
129:22 130:14
196:13 216:3
371:19
uses 200:20 216:9
216:16 349:7
usual 290:4
usually 41:1 225:17
281:21 292:15,15
324:9 351:22
utilization 4:12
142:14 143:14
194:13 259:8,18
260:14 263:10,11
269:1 285:20
324:1 348:8 355:4
355:19 398:15
utilized 272:21
utilizers 145:7
utmost 100:20

___

V

vaccine 402:21,21
vaccines 373:1
394:6
Valdez 2:3 17:14
17:15 44:14 67:2
67:2 104:5 106:18
106:19,21 177:5
210:17 214:13
231:22 233:5
234:13 235:20
241:3 246:22
248:18 249:12
260:12 262:12
263:8 264:10
265:7 266:14
267:13 344:8
valid 42:21 43:9
86:14 118:22
139:3 247:8
253:16 321:16
369:10 387:3
validated 122:1
314:3
validation 122:3,16
135:8

validity 27:14
103:12,13,15,15
103:16 128:21
138:14 148:11,16
149:18 150:10,12
167:6 170:13
176:18 186:16
187:1 190:7
191:22 195:16,17
195:22 209:22
229:17 239:1
240:19,22 241:9
242:4 243:3 247:1
247:5,16,17 248:7
265:8,20 266:5,7
266:11 309:14,19
310:1,3,8 313:20
313:21 331:21
333:2,4,7,9,9,11
333:19,22 334:5
334:11 335:3,5,7
335:10,16,19,20
336:18 337:6,11
337:13,15,19
338:5,18 374:2
376:22 387:13
402:17,20 403:7
404:3,8
validly 135:10
valuable 49:4
valuation 65:21
value 51:2,17 63:20
156:22 236:5
Value-Based 63:12
values 25:5
vanishingly 378:4
variability 246:7
variables 99:20
variation 98:9
114:4 128:2 138:8
184:3 188:3,7
189:22 223:10
228:12 254:1,4
329:5 393:13
395:7
variations 108:7
varied 25:5 280:4

varies 220:18
variety 17:20 23:14
45:13 115:18
138:2 143:13
227:9 262:17
286:20 295:11
324:11 367:12,13
various 14:4 64:7
80:5 168:13 254:2
372:12 382:18
varnish 209:18
210:7 213:10,12
224:15 225:5,10
225:12 231:13,19
257:8 274:10,11
varnishes 239:6
vary 114:10 131:13
221:2,3 229:1
varying 45:6
vast 108:22 109:10
131:15 139:7
406:21
vendors 401:6
Venkatesh 2:4 17:3
17:4 121:17
128:20 133:9
134:6 135:6 152:9
170:7 219:15
221:9 230:21
241:12 242:10,15
242:20 243:2,13
250:21 287:19
288:14,20 300:5
301:11 314:5
315:9 322:7
365:18 386:15
406:18
version 204:3
336:16
versions 376:1
versus 21:12,12
44:4 76:7 95:16
111:19 119:11
121:6 140:6
159:14 165:4
222:19 229:16
236:13 239:1,13

258:6,7 282:19
301:8 304:18
305:7,14,19 343:3
349:2 353:11,12
357:8 383:13
398:15 402:21
vessels 120:3
vetted 63:21 152:1
Vice 2:7 13:19 18:3
view 136:14 218:1
viewed 170:15
viewing 323:13
viewpoints 250:17
viral 406:9 407:4
vis 300:8,8
visit 83:16 194:21
197:7 271:6 277:2
280:9 281:21
282:19,20 289:9
294:9,13,21 323:1
324:2
visitations 300:20
visits 83:18 212:12
279:5,11 284:21
285:22 286:1
288:6 301:2
318:12 322:13
324:7
vogue 377:19
voice 173:2 174:19
176:1
volition 354:11
voluntary 61:14
348:8
volunteer 8:4
vote 40:18 100:4
116:13 123:8,11
123:12 124:10
125:2,4,18 128:9
146:3,18 147:6
150:8 151:3,4,6
151:13 152:22
155:12 156:8,9,13
156:16 157:9,18
160:16 161:14
163:7,9,10,11
165:15 166:7,22

167:6,7,8,10
168:22 169:9
170:20 173:11
174:21 175:13
178:4 180:3
181:15 183:8,10
184:16 185:15
191:11,14,21
192:16 193:9
200:2,5,5,11
204:16 206:17
207:13 229:16
232:8,11,21 233:2
233:2,3 234:8
235:10,16 236:19
240:6 241:10
246:9,19 248:10
248:12 249:22
250:11,13,15
257:16 258:17,21
261:21 262:7,10
262:11 265:1,5
266:5 267:3,7,22
268:12,14,16
269:3 295:16
296:3,11,12,16,21
297:3 299:18
304:4,8,12 306:13
307:5,14 308:7,14
308:18 309:4
310:1,7,8,20
311:16,21 312:2,5
312:7,10,15,22
313:5,15 314:2,4
314:7,12,21,22
315:3,4 327:21
328:4,21 330:14
331:11 334:13
337:9,13 341:18
341:22 342:1
343:10,18,21
344:1,4,5,11,12
344:13,14 394:12
394:18,20 395:12
397:22 398:18
399:3 400:5 402:5
404:2,17 405:14

405:18 408:2
409:10
voted 99:9,9,10
124:7 125:20,20
125:21 148:20
183:16 299:19
312:18 328:7,8,8
328:8,9 330:20,21
330:21,21 331:17
331:18,18,19
334:20,21,21,21
337:19,19,20,20
398:6,7,7,7 399:5
399:5,6,6 402:13
402:14,14,14
404:8,9,9,9 405:2
405:3,3,3,21,22
405:22,22
votes 71:7 124:19
127:19 146:16,17
146:18,19 151:2,2
151:4,7,8,9
154:13 156:6,10
156:12,12 157:8
157:13 160:13,14
160:15,15 162:4,6
162:6 163:13,16
183:13,16,17,18
183:18,19 184:10
184:12,12,13,13
185:13,14,15,16
191:9,18,19,20,20
192:14,15,15,16
198:16,17,18,18
198:19 200:2,4,4
204:16,21,22
206:12 232:21
233:1,1 234:9,10
234:11,11,12
235:16,17,18,18
235:19 246:16,17
246:18,18,19,21
248:11,11 249:8,9
249:10,10,11
250:5,7,7,8,8
259:2,3 262:7,8,9
263:3,5,5,6,6

264:5,7,8,8,9
265:2,4,4,5
266:10,11,12,12
266:13 267:8,10
267:10,11,11
268:6,8,8,9,9,21
269:2 295:22
296:16,17 297:2,3
307:11,14,14,15
308:15,17,17,18
309:10,11,12,12
309:13 310:7,9,9
310:10 311:3,5,5
311:5,6,21 312:1
312:1,2,8 313:7
328:5 330:19
331:16 334:19
337:18 339:15,17
339:20 342:4,5,6
343:16,18,18,19
394:18,19 398:5
399:4 402:11
404:6,22 405:19
408:9
voting 26:20,21
27:18 71:5,10
99:7 124:4,5
128:17 145:18
146:16 150:20
151:5 152:7
153:11 156:3,10
157:11 159:15
160:9,13 161:4,22
162:4 168:12
172:2 183:5 184:8
184:11 185:10,13
191:6,15,18
192:11,14 198:12
198:16 199:21
200:2 203:3
204:13,17 206:4,9
206:19 207:8
232:5,19,22 233:5
234:7,9 235:14,16
236:13 241:4
246:14 248:9
249:7,8 250:4,5

262:5 263:2,3
264:4,5,22 265:3
266:9,10 267:6,9
268:3,7,19,21
295:21 296:1,15
296:16 297:6
304:1,6 307:10,11
308:11,15 309:8
309:10 310:5,7
311:1,3,19,22
313:8 328:3,5
330:17,19 331:14
331:16 334:17,19
337:17,18 341:21
343:14,16 394:16
394:18 398:3,5,22
399:4 402:9,11
404:5,6,20 405:1
405:17,19 408:4
voting's 259:1
VP 19:20

W

WA 1:18
wait 125:17 153:12
312:14 314:15
waiting 124:12
127:15 128:9
151:2,3 156:6,7,9
191:9 204:16
232:20 234:8
235:15 246:16
262:6 265:1 267:7
268:5,20 296:15
308:13 310:6
311:20 328:4
341:22 394:17
399:2 405:18
walk 117:4 188:14
210:15 269:9
walking 274:16
277:10
want 7:21 8:9 9:14
11:13 18:20 19:6
19:13 41:11 44:12
47:1,9 55:22
63:20 64:1 65:20

65:22 67:21 68:22
69:12 71:13,22
82:15 86:3 91:4
96:3 101:14 105:2
113:6 116:8,19
119:2 125:22
130:17 142:16
147:11 159:5,16
162:22 163:18,20
165:14,15,21
168:1 169:21
172:4,18 175:18
175:19 176:15,16
177:2 179:15
180:1 185:22
186:9 187:4
190:10 201:13
204:1 205:20
208:9 211:3
239:11,21 243:3
245:11 247:20
256:10 258:10
276:14 278:12
280:11 303:3
312:10,17,18
313:18 314:2
315:17 327:7
328:20 335:4,6
344:2 345:18
346:22 349:10
354:17 362:22
369:12 370:10
374:19,20 375:16
380:7 384:2 385:4
386:2 387:18
388:1 391:4,9,11
408:7
wanted 5:14,16
22:12 32:1 34:2,5
67:16 68:21 77:4
77:7 84:12 104:9
106:2 116:17
154:16 175:13
176:6 181:14
190:18 192:19,22
202:5 208:7 217:1
236:20,21 245:8

248:6 250:14
256:7,22 272:15
315:7 330:1,3
349:17 359:22
wanting 231:22
373:11
wants 103:22
213:18 272:12
359:2 388:17
391:15
washed 385:22
Washington 1:9
16:3 76:20
wasn't 52:19 106:8
106:9 151:11
178:5 201:5 242:2
313:20 321:4
322:18,18 332:17
401:3
water 34:1 91:7,11
91:15,20 94:4,8
95:7,9,16 386:8
386:13,20
waters 91:20
watershed 88:20
way 29:20 47:9
67:14 80:17 81:7
87:17 92:2 96:12
97:22 107:11
111:9,15 117:10
117:13 120:19
130:12 135:5
137:14 139:9
145:3 168:6
170:20 171:12
175:9 176:2 188:8
201:6 206:20
219:11 220:14
240:4 243:9
244:18 245:17
252:7 283:6
299:19 316:22
326:10 327:13,18
340:11 359:8,19
362:3 363:3,18
364:4 365:4
367:18 368:2

371:13 380:17
390:5
ways 20:6 43:21
67:3,5 108:11
129:19 143:13
164:8 174:20
215:7 286:17
313:1 323:22
we'll 22:7,20 23:8
23:19 26:15,17
27:16,18,19 38:3
39:22 40:14 47:14
47:15 49:7 56:10
62:20 70:5,18
73:12 74:2,13
89:12 90:22 91:2
95:22 99:16 100:1
100:4,11 116:11
125:13 140:21
145:15 150:9
152:20 154:1,15
157:16 162:19,21
163:8,9,13,17
175:14,15 179:16
180:1 185:17
198:20 200:9
205:15 207:11,12
210:13 232:10
233:7 237:1 241:6
241:7 255:13
256:4 266:5
273:10 291:19
304:12 328:17
344:13 345:1,11
347:4 349:19
360:7 362:2
390:16 391:2,3
392:2 399:8
404:17 408:15,16
410:2,3
we're 7:7 9:14,17
13:12 16:12 20:17
20:18 23:17 26:11
27:13 29:8,12
30:14,21 31:7
37:20 39:2 41:17
46:20 48:22 53:22

18:16 39:10,10
40:2 57:13 68:8,9
82:12 93:16 96:2
96:7 98:12 115:3
162:11 197:11
204:20 208:6
209:18 211:19
222:2 225:18
241:15 242:16
244:6,6,15,20
245:16,22 252:14
252:19 253:2,9,18
254:5,7 270:2
279:12 293:20
305:9,14,21
319:12 325:22,22
326:1,1,1,1 341:5
341:6 348:15
374:11 389:7
year's 282:16
yearly 318:11
years 9:10 10:9
11:19 12:13 13:2
14:7 20:3,13,15
30:2 38:14 39:7
60:16 74:17,20
76:19 92:6,18
93:1,7,8 114:9,17
118:13 153:22
160:2,3 187:13
197:12 199:13,14
207:3,4 208:3
212:9 219:20
225:4,11 226:16
241:21 246:6
251:2,7 254:21
255:5,14 269:22
280:1 282:13
315:14,15,17,22
316:3,19 319:20
320:9,10,14,19,22
324:7 325:6,11
336:19 341:4
346:18 366:11
377:18,22 378:5
392:7,12 394:3,10
399:12,22

yeses 147:18
yesterday 95:8
361:7
York 8:21 18:4,10
405:8
young 93:11
younger 217:19
223:4 224:4,10
225:4,11 230:1

Z

zero 160:15 183:18
183:18,19 184:13
184:13 185:16
191:20 192:16
198:18,19 234:11
234:12 235:18,19
249:10,11 263:5,6
264:8,9 265:5
266:13 267:11,11
268:9,9
zip 373:11 395:6
zone 313:19

0

0 309:13 310:10
311:5,6 328:7
334:21 337:19
398:7 399:6,6
402:14,14 404:9
405:3,3,22,22
408:9
02 118:6
0272 17:11
0274 17:11
03 118:6
0601 117:15
0602 117:15
0603 117:15
0727 3:17

1

1 97:12 102:19
116:9 125:21
145:5,6 163:8
180:2,5,15 181:11
183:2 208:3

215:13 216:22
217:12 219:5
232:8,16 234:15
238:8 245:1,3
248:8 249:6 250:2
251:18 258:20
262:1,22 264:3,21
266:8 267:5 268:2
268:18 293:20
294:21 295:19
296:4 297:3 304:1
305:2 307:9,14
308:10,18 309:7
310:4,8,22 311:18
312:2 328:1
330:16 331:13
334:16 337:16,20
341:20 342:6
343:13 394:16,20
398:2,7,21 402:8
404:4,9,19 405:16
408:6
1(a) 97:14,21 98:3
125:18,19 126:13
182:2,6,9,10
183:16
1(b) 98:7 125:13
126:13,14 127:22
128:1 183:22
184:2,11
1(c) 99:2 126:7,21
127:3,19 184:16
185:3,13
1.48 396:5
1.64 396:6
10 143:19 204:20
296:10,10,17
297:2,20 303:22
307:14 312:8
331:18 342:5
344:20,21,22
345:1,1
10-14 4:7
10-minute 72:16
100 139:22
100,000 346:17
405:11,12

1030 1:9
108 230:13
11 93:8 111:20
112:1 160:15
248:10 298:4,21
304:2,4 308:17
312:8 321:13
328:7,12 342:4
11:04 154:9
11:13 154:10
12 35:15 68:1
111:20 112:1
128:14 146:17
182:17 265:4
266:12 284:8,9
309:12 310:9
317:11 321:13
12:11 205:18
12:35 205:16
12:45 205:16
12:48 205:19
121.5 405:11
13 184:12 198:17
235:17 241:16
246:18 328:13,16
330:20 343:18
398:6 404:8
14 151:7 156:11
183:17 204:20
234:11 268:8
1419 83:20
15 36:19 92:6
125:20 147:10
191:20 233:1
246:17 344:15
391:10 399:5
15th 1:9
16 3:18 148:18
185:14 192:15
264:7 267:10
334:20 337:19
17 259:2 311:4
346:18 366:11
392:7,12 399:12
399:21 402:13
405:21
176 4:8

18 162:6 204:21
217:18 219:20,22
220:1,13,16,19,19
221:11 224:5
225:12,20 242:20
263:4
18.7.7 225:9
180 112:16 321:13
19 32:13 216:4
269:2
1a 215:9 232:14,15
261:22 326:18
1b 234:5
1b.2 241:14
1c 235:12
1st 63:7 67:20 68:2

2

2 97:10 145:6,7
163:10 232:17
234:6 235:13
241:17 243:16
245:1,4 246:13
248:8 249:6 250:2
258:20 262:2,22
264:3,21 266:8
267:5 268:2,18
295:19 307:9,15
308:10 309:7
310:4,22 311:18
315:14 328:1,9,12
330:16,21 331:13
331:18 334:16,21
337:16 341:20
343:13,19 394:16
396:10 398:2,21
402:8 404:4,19
405:3,16 408:6
2-1/2 396:11
2-phase 32:10
2-year 10:2,20 15:8
15:17
2(a) 146:6 152:11
152:12 191:1
2(a)(1) 100:22
146:6 191:1
2(a)(2) 146:7 191:2

2(b) 150:12
2(b)'s 103:19
2(b)(1) 100:22
   192:1
2(b)(2) 150:13
   192:2
2(b)(3) 150:15
   192:4
2(b)(4) 150:16
   192:4
2(b)(5) 150:17
   188:1 189:13
   192:5
2(b)(6) 150:17
   192:6
2(b)(7) 192:7
2.26 225:9
2.46 396:10
2.5 396:10
2.6 115:15 231:4
2/3rds 396:7
2:00 68:1
2:10 269:11,15
2:19 269:16
2:20 269:13
20 127:21 156:8
   157:9 394:10
   405:2
200-odd 339:5
2000 82:13
2005 396:7,17
2007 405:10
2010 80:16,20
   241:16 243:14,17
   244:15
2011 241:16 243:15
   243:18 244:15
   348:12 396:16
   405:11
2014 1:6
2015 40:4
205 3:19
208 4:11
21 124:19,20
   127:19 146:16
   160:13 163:15
   185:13 208:3

215:13,20,21
216:8,22 217:12
217:15 219:6
220:4 225:20
234:16 238:8
269:22 293:20
294:21 296:13
315:14 328:16
394:19
22 3:9 241:17,18
   243:15,17 328:13
   408:9
24 352:1 356:5
   403:4
25 35:14
2508 4:3 96:1
   162:10 409:7
2509 4:6 162:21
   176:5 179:3
   186:11 204:19
   409:8
2511 4:12 259:8
   261:9 269:1 409:9
2517 4:14 269:17
   409:10
2518 4:16 315:12
   409:11
2528 4:9 207:15
   259:3 409:8
259 4:13
27 230:15 241:18
270 4:15
28 3:10
29 1:6
29th 40:11
2A 331:20,21 338:5
2a2 242:11
2B 338:5
2b2 242:11
2b6 242:11
2nd 68:2

3
---

3 12:15 18:15 105:5
   152:21 163:10
   232:17 234:6
   235:13 241:15

243:14 245:1,4
246:13 248:8
249:6 250:2 262:2
262:22 264:3,21
266:8 267:5 268:2
295:19 307:9
308:10 309:7,12
310:4,22 311:18
328:1 330:16,21
331:13,18 334:16
337:16 341:20
343:13,18 346:18
366:10 392:7,12
398:2,21 399:11
399:21 402:8
404:4,19 405:16
3-hour 16:19
3-year 9:16,20 15:2
   16:5,13 17:1
   20:15 22:15 38:9
3(a) 155:18 198:6
3(b) 153:6 155:19
   198:7
3(c) 155:19 198:7
3:00 390:22
3:45 345:9
3:57 345:9
30 78:10 156:7
   377:21
30th 40:11
316 4:18
32 339:18
347 3:18
35 241:16 243:14
37 346:13 391:13
391 4:20
3rd 40:14

4
---

4 82:7 159:8 232:17
   234:6 235:13
   246:14 248:8
   249:7 250:3 262:2
   263:1 264:4,22
   266:8 267:6 268:3
   295:19 296:9
   297:3 304:3 305:3

307:10 308:11,17
309:8 310:4 311:1
311:5,18 328:2,8
330:17,20 331:14
334:17,20 337:16
341:20 343:14,17
398:3,22 402:9
404:4,20 405:17
4(a) 159:22 199:12
4(b) 158:11 159:4
   159:10,18 160:3
   199:15
4(c) 160:5 199:17
4,651 348:12
4:45 390:9,10
40 303:19 313:19
   377:18
410 4:22
416 80:14 82:3
   216:16 287:5
45 163:14
46 348:10,11
48 3:15
4b 250:22
4th 40:14

5
---

5 3:4 125:20 232:18
   241:18 262:3
   295:20 296:7,8
   308:17 312:2
   328:2,8 337:20
   390:21 402:13
   405:21
5(a) 182:12
5(b) 182:12
5(c) 182:12
5:06 410:5
50 95:10 140:2
   299:6 398:13
50-50 279:6
50/50 250:17
51 115:4
59 328:14 343:22

6
---

6 4:3 59:14 86:22

96:2,6 98:10,12
162:10 182:14
219:20,22 220:1
220:18 221:10,20
222:5 224:5 225:4
225:11,12 226:16
230:22 231:2,9
238:19 297:2
304:4 309:11
6:30 409:15
60 127:13 163:17
   248:15 298:22
   303:19 312:8
   313:19 344:1
64 184:21
642 333:18
67.5 405:12
6th 40:15

7
---

7 3:6 59:19 82:5
   297:17 312:1
   331:17 399:5
70 34:17
700 34:12
72 352:1
727 391:20 408:10
74 269:17

8
---

8 60:3 307:13 310:9
   312:1 398:7 404:8
8:30 1:9 410:1
8:33 5:2
80 140:1
86 207:17
88 395:15
89 80:18

9

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Health and Well Being
                   Steering Committee Meeting

Before: NQF

Date: 04-29-14

Place: Washington, DC

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
true and accurate record of the proceedings.

_____
Court Reporter